THE COMMONWEALTH OF KENTUCKY
ON BEHALF OF

THE CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MEDICAID MANAGED CARE SERVICES

November 2022

Revised: Month 2026

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1.0 INTRODUCTION

Kentucky Medicaid is a state and federal program authorized by Title XIX of the Social Security Act to provide health care for eligible, low-income populations. These populations include children, low-income families, pregnant women, the aged, and the disabled. Eligibility for these groups is determined by several factors, including family size, income, and the Federal Poverty Level (FPL). Eligibility for people who receive Supplemental Security Income (SSI) and the aged, blind, or disabled are based on additional requirements such as income and resource limits.[1]

As of July 2026, approximately 1.35 million Kentuckians are beneficiaries of Medicaid or the Kentucky Children's Health Insurance Program (KCHIP).[2] [3] Approximately 90% of these individuals are enrolled in managed care plans under the Section 1915(b) waiver or Alternative Benefit Plan authority.

The Kentucky Medicaid Managed Care (MCO) Quality Strategy described in this document represents a cooperative effort across all partner groups. As designed, the strategy is managed by the Department for Medicaid Services (DMS) and is iterative, dynamic, and responsive to changes in the marketplace as well as the evolving needs of beneficiaries.[1] The methodology used to develop this strategy is based on the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Toolkit* (Toolkit) released by the CMS in June 2021. The strategy builds upon the existing *Kentucky Strategy for Assessing and Improving the Quality of Medicaid Managed Care Services,* adopted in February 2023.

As prescribed by the Toolkit, an Interdisciplinary Team of partners was convened to assist in developing the Quality Strategy. In-depth semi-structured interviews of key informants were conducted, analyzed, and used as an information resource. Key informants included beneficiaries, advocacy organizations, multiple provider types, and healthcare systems. MCOs were engaged as members of the Interdisciplinary Team. For the revised Quality Strategy, information and input was gathered through the public posting and solicitation of comments on the strategy. Other information sources include those identified in the Toolkit; specifically, Core Set Reports (PIPs, Focus Studies, etc.), EQR reports, and Managed Care Plan documents.

1.1 Applicable Federal Quality Strategy Requirements

In accordance with 42 CFR 438.340(a) and 42 CFR 438.340(b), at a minimum, quality strategies must address:

1. The State-defined network adequacy and availability of services standards for §438.68 and §438.206
2. The State's goals and objectives for continuous QI, which must be measurable and take into consideration the health status of all populations in the State served by the MCOs
3. A description of:
    a) The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c)
    b) The PIPs to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO or Prepaid Inpatient Health Plan (PIHP).

[1] (Monthly Medicaid Counts n.d.)
[2] (Monthly Medicaid Counts n.d.)
[3] (Monthly Medicaid Counts n.d.)

4. Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP and Primary Case Management Model (PCMM) entity contracts that have shared savings, incentive payments, other financial rewards
5. A description of the State's transition of care policy required under §438.62(b) (3)
6. The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities
7. For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of Subpart I of Part 348
8. The mechanisms implemented by the State to comply with §438.208(c) (1) relating to the identification of persons who need long-term services and supports (Note: this is not relevant to Kentucky Medicaid Services as long-term services are not included in the Managed Care Contract)
9. The information required under §438.360(c) relating to non-duplication of external quality activities
10. The State's definition of a "significant change" for the purposes of paragraph (c) (3) (ii) of this section.

1.2 Cross-Cutting Considerations

This strategy includes a focus on cross-cutting issues identified in development of the 2023 Quality Strategy. These include:

- Review of performance on CHIP Child and Adult Core Sets to prioritize and articulate the QI goals and objectives. This includes comparisons to both the national median for measures and peer-state performance.
- Alignment of the quality strategy with other managed care tools. This includes annual EQR reports, QAPI, directed payments, and sanction activities.
- Health disparities and equity initiatives.
- Intermediate sanctions linked to quality performance.

1.3 Population Health in Kentucky

The general health of the Kentucky population ranks poorly amongst the rest of the country. Many factors contribute to the poor health of the Commonwealth including socioeconomic status and employment. As of 2024, 56.9% of the population aged 16 years and older participated in the civilian workforce.[4] The median household income in 2024 was $64,526, which was is $17,078 less than the United States median, and 15.6% of people in the state of Kentucky lived in poverty, compared to the national average of 12.1%[5]. In addition, 14.5% of the Commonwealth experiences food insecurity and is unable to provide adequate food for one or more household members due to a lack of resources.[6]

Behavioral risks that have contributed to poor health outcomes in the Commonwealth include:

- 17.2% of adults reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days (48th of 50 states, with only two states reporting higher smoking prevalence)[6]
- In 2023, Kentucky ranked 44th nationally in deaths due to drug injury per 100,000 (45.9). The national rate was 31.4. [6]

[4] (U.S. Census Bureau n.d.)
[5] (U.S. Census Bureau n.d.)
[6] (American Health Rankings n.d.)

- 28% of adults reported doing no physical activity or exercise other than their regular job in the past 30 days in 2024, ranking 46th nationally.[6]
- 8.9% of adults reported appropriate fruit and vegetable consumption (11th in the country)

Additional notable public health issues of the Commonwealth include:

- 28.3% of adults have been diagnosed with a depressive disorder (48th in the country)[6]
- 50.1 deaths per 100,000 population occurred due to drug injury (49th in the country)[7] AHR 2023 data shows 45.9 per 100,000 population, ranked 44th nationally (SA)[6]
- 8.8% of infants weigh less than 2,500 grams (5 pounds, 8 ounces) at birth (32nd nationally) [6]
- 18% of adults have been diagnosed with multiple chronic conditions (48th in the country)[6]
- 37.2% of adults are obese (40th in the country) [6]
- In 2022-23, 2.2% of Kentucky high school youth reported currently using a tobacco product (36th nationally).[6]

Tables 1-3 below include additional information supporting population health priorities and the summary of the proposed Quality Strategy updates in Table 12.

Table 1:Kentucky State Health Assessment Data

Public Health Issues and Behavioral Risks	State Rank	State Value	U.S. Value
Drug Deaths (per 100,000 population)	45	50.3	32.4
Opioid Induced Deaths (per 100,000 population)	50	39.9	28.1
Non-Medical Drug Use (% of adults)	45	20.9%	17.6%
Food Insecurity (% of households)	45	14.5%	12.2%
Fruit and Vegetable Consumption (% of adults)	11	8.9%	7.4%
Income Inequality (80-20 Ratio)	42	5.04	4.87
Dental Care Providers (per 100,000 population)	32	59.5	65.8
Mental Health Providers (per 100,000 population)	27	328.1	344.9
Primary Care Providers (per 100,000 population)	16	317.1	283.4
Uninsured (% of population)	12	5.4%	7.9%
Colorectal Cancer Screening (% of adults ages 45-75)	10	64.0%	61.8%
Tobacco Use: Current Smokers (% of adults)	Not Available	19.6%	14.4%
Tobacco Use: Smoking During Pregnancy (per 1,000 live births)	Not Available	12.6	4.6
General Health: Fair or Poor Health (% of adults)	Not Available	22.6%	14.8%
Asthma (% of adults)	Not Available	11.7%	9.8%
Coronary Heart Disease (% of adults)	Not Available	6.1%	3.8%
Heart Disease Deaths (per 100,000 population)	Not Available	301.0	161.5
Diabetes (% of adults)	Not Available	13.8%	10.9%
Kidney Disease Deaths (per 100,000 population)	Not Available	24.0	16.4
Severe Housing Problems	Not Available	13.0%	17.0%

*Data compiled from StateHealthAssessment2023.pdf and American Health Rankings

Table 2:Youth Kentucky State Health Assessment Data

Youth Public Health Issues and Behavioral Risks	State Rank	State Value	U.S. Value
Adverse Childhood Experiences (% of children ages 0-17)	42	19.6%	14.5%
Childhood Immunizations (% of children by age 24 months)	39	64.1%	66.9%
HPV Vaccination (% of adolescents ages 13-17)	47	47.9%	61.4%

[7] (Kentucky Department for Public Health 2023)

Youth Public Health Issues and Behavioral Risks	State Rank	State Value	U.S. Value
Teen Births (Births per 1,000 females ages 15-19)	47	21.8	13.6
Low Birth Weight (% of live births)	33	8.9%	8.6%
Infant Mortality Rate (IMR) (per 1,000 births)	Not Available	5.9	5.4
Neonatal Abstinence Syndrome (NAS) Rate (per 1,000 births)	Not Available	19.4	6.0
Youth Obesity (High School Aged)	Not Available	19.6	16.3
Nutrition and Physical Activity			
• Did not eat vegetables	Not Available	10.8%	9.3%
• Did not drink milk	Not Available	37.3%	35.7%
• Drank a can, bottle, or glass of soda or pop two or more times per day	Not Available	18.5%	8.5%
• Did not eat breakfast on all 7 days	Not Available	77.0%	75.5%
• Not physically active for at least 60 minutes on at least 1 day	Not Available	15.9%	15.8%
• Spent 3 or more hours per day on screen time (not including time doing schoolwork)	Not Available	73.7%	75.9%
Children in Poverty	Not Available	21.0%	17.0%
Youth Alcohol Use	Not Available	13.0%	22.7%
Youth Marijuana Use	Not Available	8.2%	15.8%
Youth Cigarette Use	Not Available	4.5%	3.8%
Youth Smokeless Tobacco Use	Not Available	4.9%	2.5%
Youth Electronic Vaper Product Use	21	19.7%	16.8%
Youth Opioid Use	Not Available	1.3%	6.0%

*Data Compiled from 2023 Youth Risk Behavior Results and CDC Youth Online - YRBS

Table 3:Data from 2023 Area Development District Profiles (ADD) Kentucky Behavioral Risk Factor Survey (KyBRFS)

List of Variables	Nationwide	Kentucky
Alcohol Consumption		
Adults who reported heavy drinking	6.4	5.4
Adults who reported binge drinking	16.1	13.5
Cardiovascular Disease		
Adults who have ever had a heart attack	4.0	5.8
Adults who have coronary heart disease	3.8	6.1
Adults who have ever had a stroke	3.0	4.6
Depression		
Adults who have ever been diagnosed with a depressive disorder	20.5	25.6
Diabetes		
Adults who have diabetes	10.9	13.4
Health Care Access/Coverage		
Adults who have health care coverage	92.9	93.7
Adults aged 18-64 who have health care coverage	90.9	92.1
Respiratory Disease		
Adults who currently have asthma	9.8	11.6
Adults who have COPD, emphysema, or chronic bronchitis	6.1	11.6
Tobacco Use		
Adults who are current smokers	14.4	20.5

The care provided to Medicaid beneficiaries needs to be intentionally prioritized to address the health concerns identified within the state. This quality strategy addresses several of these health concerns within the identified goals and objectives. With the proper prioritization of performance improvement projects and value-based programs, MCOs should improve the care provided to Medicaid beneficiaries and thus help to improve the health of the Kentucky population.

Building on the current Quality Strategy and its activities, DMS will continue to implement a comprehensive approach to transforming Medicaid through innovative delivery system reforms for substance use disorder (SUD), chronic disease, and managed care that will improve both quality and outcomes.

DMS seeks to achieve this overall vision by focusing on the following quality goals:

- Improve enrollee health outcomes through improved screening and treatment retention for individuals with behavioral health conditions
- Improve outcomes associated with people with chronic conditions such as diabetes mellitus (DM), hypertension (HTN), Chronic Obstructive Pulmonary Disease (COPD), and asthma
- Increase preventative service utilization
- Increase access to high-quality care while reducing unnecessary spending
- Improve outcomes for identified special populations
- Improve assessment, referral, and follow-up for SDoH. Foundational to achieving this vision are several components:
    - Access to care
    - Clear agreement on evidence-based practice
    - Adoption and optimization of health delivery systems including information technology
    - New payment models that reward quality and value

Finally, DMS will work collaboratively with MCOs, health care providers, enrollees and families, and other partners to continue to advance:

- Identification of shared goals and objective selection of interventions that achieve these goals and objectives
- Measurement and monitoring of progress toward these goals and objectives
- Definitions for the starting point and targets for performance
- Feedback loops and transparency, including a continuous review of performance relative to the targeted goals and objectives.

2.0 MANAGED CARE IN KENTUCKY

The Kentucky DMS contracts with MCOs to provide coverage for most Kentucky Medicaid recipients. DMS oversees the Medicaid program including the MCOs which process claims and provide disease management, care coordination, prior authorization (PA), and other services for their recipients. Kentucky Medicaid is currently serviced by five MCOs using risk-based contracts. All MCO contracts have 1915(b) authority and serve both children and adult Medicaid beneficiaries (see Table 4).

Table 4: Managed Care Contract Information

Plan Name	Managed Care Plan (MCO) Type	Managed Care Authority	Populations Served
Aetna Better Health of Kentucky (ABHKY)	MCO	1915(b)	Children and Adults
Humana Healthy Horizons in Kentucky (Humana)	MCO	1915(b)	Children and Adults
Passport Health Plan by Molina Health Care (Passport)	MCO	1915(b)	Children and Adults
UnitedHealthcare Community Plan (UHC)	MCO	1915(b)	Children and Adults
WellCare of Kentucky (WellCare)	MCO	1915(b)	Children and Adults

During the last national census, conducted in 2020, the population of Kentucky was determined to be 4,505,836.[8] Only 4.3% of Kentucky adults reported having no healthcare coverage, less than the U.S. median prevalence of 7.1%,[9] and as of July 2026, there were approximately 1.35 million Kentucky Medicaid beneficiaries, meaning approximately 31% of Kentuckians receive Medicaid benefits. Of these beneficiaries, nearly 90% are enrolled to receive care through one of the MCOs, while the other 10% are enrolled in Fee-for-Service (FFS) under a waiver program. Given the prevalence of managed care plans, enhanced MCO cross-collaboration and engagement with additional partners will be key in moving toward improved positive outcomes for Kentuckians. Table 5 depicts the market share breakdown between each of the MCOs and FFS as of July 2026.

Table 5: July 2026 Medicaid Market Share

Plan	Unduplicated Member Count	Market Share
ABHKY	215,287	16%
FFS	162,636	12%
Humana	189,052	14%
Passport	256,716	19%
UHC	146,681	11%
WellCare	376,203	28%
Total	**1,346,575**	**100%**

KCHIP is free health insurance for families without health insurance with an annual household gross income at or less than 218 percent of the federal poverty level for the following qualifications:

- Children under the age of 19
- Currently pregnant women
- Women within one (1) year postpartum

[8] (United States Census Bureau - Kentucky 2020 Census n.d.)
[9] (Kentucky Department for Public Health 2023)

A family is considered a child or children, and the natural, adoptive or stepparents residing in a household. Due to changes in the Affordable Care Act (ACA), effective January 1, 2014, KCHIP eligibility is determined using the Modified Adjusted Gross Income and family size based on the tax filing unit of the household.[10]

DMS has created an informational toolkit to raise awareness about the availability of children's health insurance. These materials provide an overview with helpful tips and information about enrolling in KCHIP or Medicaid. These materials will also help families navigate the return of annual child renewals, starting with those who had a July 2025 renewal. Through the COVID-19 Public Health Emergency flexibility, coverage for children was automatically extended at the same time as their annual renewal. This flexibility ended on June 30, 2025.[7]

According to the Kentucky Cabinet for Health and Family Services (CHFS), as of August 2025, there are a total of 617,752 individuals receiving coverage under the KCHIP[11]. Table 6 below shows a breakdown of Kentucky Medicaid and KCHIP counts as of April 2026. Note that in spring 2022, all children were transitioned to KCHIP Expansion. KCHIP beneficiaries consist of pregnant women who are above the 195% expansion income limit and only qualify using the KCHIP 213% FPL income standard (218% with the 5% disregard). KCHIP expansion now includes behavioral health, and the Early Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit up to 21 years old.

Table 6: April 2026 Kentucky Child Medicaid Counts

KCHIP	KCHIP Expansion	Medicaid	Grand Total
1	107,373	449,604	556,978

As of January 1, 2025, Anthem Blue Cross Blue Shield is no longer serving Kentucky Medicaid beneficiaries. The relative market share for MCOs is depicted in Table 7.

Table 7: Kentucky Medicaid Enrollment Trends 2020-2025

MCO	Enrollment 8/2020	Enrollment 8/2021	Enrollment 8/2022	Enrollment 8/2023	Enrollment 8/2024	Enrollment 8/2025	Percent Change
ABHKY	215,939	245,717	244,053	243,961	223,289	227,023	+5.16%
Anthem	146,573	163,455	173,881	178,933	159,265	N/A	N/A
FFS	251,779	150,466	157,056	143,545	146,955	151,117	-39.98%
Humana	156,255	166,948	167,231	164,609	144,388	215,917	+38.18%
Passport	316,584	326,214	332,759	325,986	281,574	277,163	-12.45%
UHC	N/A	38,543	83,052	95,424	83,064	157,407	+308.39%
WellCare	454,971	471,018	486,411	476,439	420,537	408,335	-10.25%
Total	**1,542,101**	**1,562,361**	**1,644,443**	**1,628,897**	**1,459,072**	**1,436,962**	**-6.82%**

2.1 Evolution of Medicaid Managed Care in Kentucky

In December 1995, the Commonwealth of Kentucky received approval from Centers for Medicare and Medicaid Services (CMS) under Section 1115 waiver authority to establish a statewide MCO program. In the fall of 2000, following the withdrawal of a key healthcare partner from the program, Kentucky Medicaid halted plans to implement a statewide risk-based managed care program. The partnership with University Health Care (doing business as Passport Health Plan) continued service in Region 3

[10] (KY.gov n.d.)
[11] (Monthly Medicaid Counts n.d.)

(Jefferson and 15 surrounding counties) and the rest of Kentucky's Medicaid enrollees were enrolled in FFS system.

In 2011, with increasing Medicaid health care expenditures and a growing eligible population, Kentucky once again turned to risk-based managed care as a solution. Following a careful procurement process, risk-based, state-wide, managed care was implemented. The Patient Protection and ACA allowed DMS to further expand Medicaid eligibility in 2014.

In January 2018, the initial Section 1115 Demonstration Waiver was approved by CMS, entitled Kentucky HEALTH (Helping to Engage and Achieve Long Term Health). The Demonstration also included a SUD Demonstration implemented July 1, 2019. The Kentucky HEALTH program was not implemented due to legal decisions regarding components of the program and was rescinded by DMS in December 2019 while the other components of the waiver remained.

KY filed an amendment to the SUD 1115 in November 2020 to include coverage of SUD services for justice-involved individuals while incarcerated. CMS approved the TeamKY (formally known as Kentucky HEALTH) 1115 five-year extension request and was granted approval effective January 1, 2025-December 31, 2029, including continued authority of the reentry initiative for justice-involved individuals who are more likely to suffer from substance use and mental health related issues than non-justice-involved individuals, as well as newly approved severe mental illness (SMI) demonstration.

Oversight and guidance are provided by the Medicaid Oversight and Advisory Committee (MAC) by statutory mandate that includes oversight on the implementation of Kentucky Medicaid, as well as access to services, utilization of services, quality of services, and cost containment.

Technical Advisory Committees (TACs) provide additional guidance to Kentucky Medicaid and are also statutorily created. Each committee represents a specific provider type or individuals representing beneficiaries. Most members of the TAC are appointed by the professional associations they represent.

Medicaid established the Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) to meet new federal rules for member engagement. The BAC exclusively includes current/former members and caregivers, while the MAC features a diverse mix of providers, advocates, and BAC representatives. Both advise the Cabinet for Health and Family Services.

- **MAC:** In accordance with new federal requirements, the Advisory Council for Medical Assistance expanded to include representatives from more organizations and more individuals with lived Medicaid experience. The name changed to the Medicaid Advisory Committee but the acronym, MAC, is the same.
- **BAC:** DMS has created a new group called the Beneficiary Advisory Council (BAC) for current Medicaid members, or people who used to be members, along with their families and/or caregivers. The BAC is meant to help make decisions about Medicaid and make sure that people who have used Medicaid can share their ideas. You can find more information about the BAC, including its list of members, on the BAC website, BAC KYMedicaid. This website also has the meeting dates, agendas, meeting notes, and presentations[12].

[12] (Kentucky Cabinet for Health and Family Services n.d.)

3.0 THE KENTUCKY MEDICAID QUALITY STRATEGY

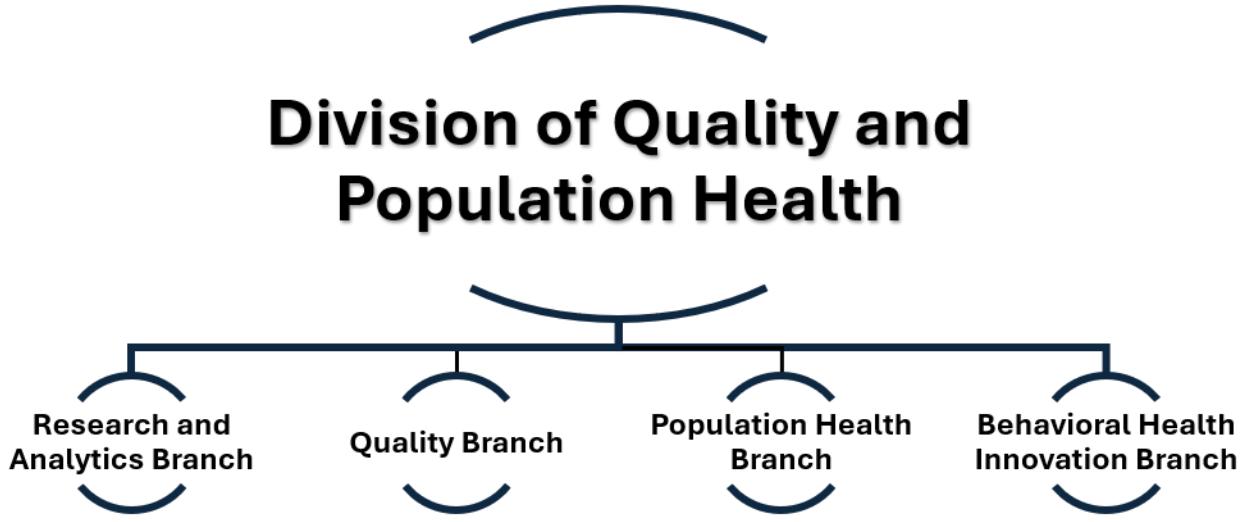
The current Quality Strategy is central to the activities of DMS, MCOs, providers, and other partners and was developed, as recommended in the Toolkit, with input, guidance, and information provided across partner groups. In addition, the membership of MAC and TACs informed the development of the 2023 Quality Strategy via key informant interviews. The quality strategy proposed in this document represents a continuation and evolution of the existing strategy.

3.1 Reorganization of the Division of Quality and Population Health

In July 2022, DMS renamed the Division of Program Quality and Outcomes to the Division of Quality and Population Health (DQPH) to reflect the agency's goals in ensuring access to quality services and improving the health and outcomes of the entire population it serves. To meet these goals, DMS created the Equity and Determinants of Health Branch to focus on policies and programs that remove barriers to access and promote overall health through population health management initiatives. Upon further reorganization in August 2024, the Equity and Determinants of Health Branch was incorporated into the Population Health Branch.

The Research and Analytics Branch was created to assist with ensuring that decisions are data-informed and that trends are identified and addressed. The Disease and Case Management Branch has been refashioned into the Population Health Branch, and the Managed Care Oversight Quality Branch has been renamed the Quality Branch. The Managed Care Oversight Contract Management Branch has been re-established under the Division of Health Plan Oversight. The Behavioral Health Innovation Branch was added in the Spring of 2026. The new structure for the DQPH is depicted in Figure 1.

Figure 1: Organization of the Division of Quality and Population Health



3.2 Delivery System Reforms

This Quality Strategy is also central to DMS system reforms. These system reforms are designed to support the quality goal of improving care and care experiences, reducing costs, improving population health, and advancing health equity across the Commonwealth. Figure 2 provides a summary of the Quality Strategy updated goals and objectives.

The goals and objectives represent a continuation of goals and objectives from the current Quality Strategy based upon EQR assessments, MCO performance reviews, 2022 stakeholder interviews and input from advisory and oversight committees, CMS guidance, and changes in the marketplace. Focus Studies and PIPs informed and shaped the new strategy.

In the revised strategy, objectives are more targeted and are linked to Core Measures where possible. There is an increased emphasis on access, disparities, and the SDoH. Additional coordination and standardization of QAPI and value-based initiatives as well as their linkage to the Quality Strategy are also included. Finally, the revised strategy continues to support a larger framework for review and continuous improvement.

Figure 2: Quality Strategy Goals and Objectives Supporting System Reform

Population Health Focus	Evidence-Based Care	Access	Value and Quality	Address Disparities	A Healthier Kentucky
Improved screening & treatment retention for individuals with behavioral health conditions	**Improved outcomes for individuals with chronic diseases**	**Increased use of preventative services**	**Access to high-quality care promoted, & unnecessary spending reduced**	**Improved outcomes for identified special populations**	**Improved assessment, referral, & follow-up for SDoH**
Increase treatment retention Minimize risk & adverse impacts of medication treatment Decrease number of Emergency Department visits Increase utilization of psychological care	Promote evidence-based treatment for individuals with: HTN DM COPD Asthma	Increase preventive cancer screenings Increase childhood physical activity Improve childhood wellness visits Support tobacco and smoking cessation	Improve relationships between providers and MCOs Focus on value-based care Improve access to care	Improve pregnancy and newborn outcomes Improve care coordination for youth transitioning out of foster care	Improve the quality of SDoH assessment Increase the number of enrollees who receive a SDoH assessment

A summary of revisions to the strategy includes the following.

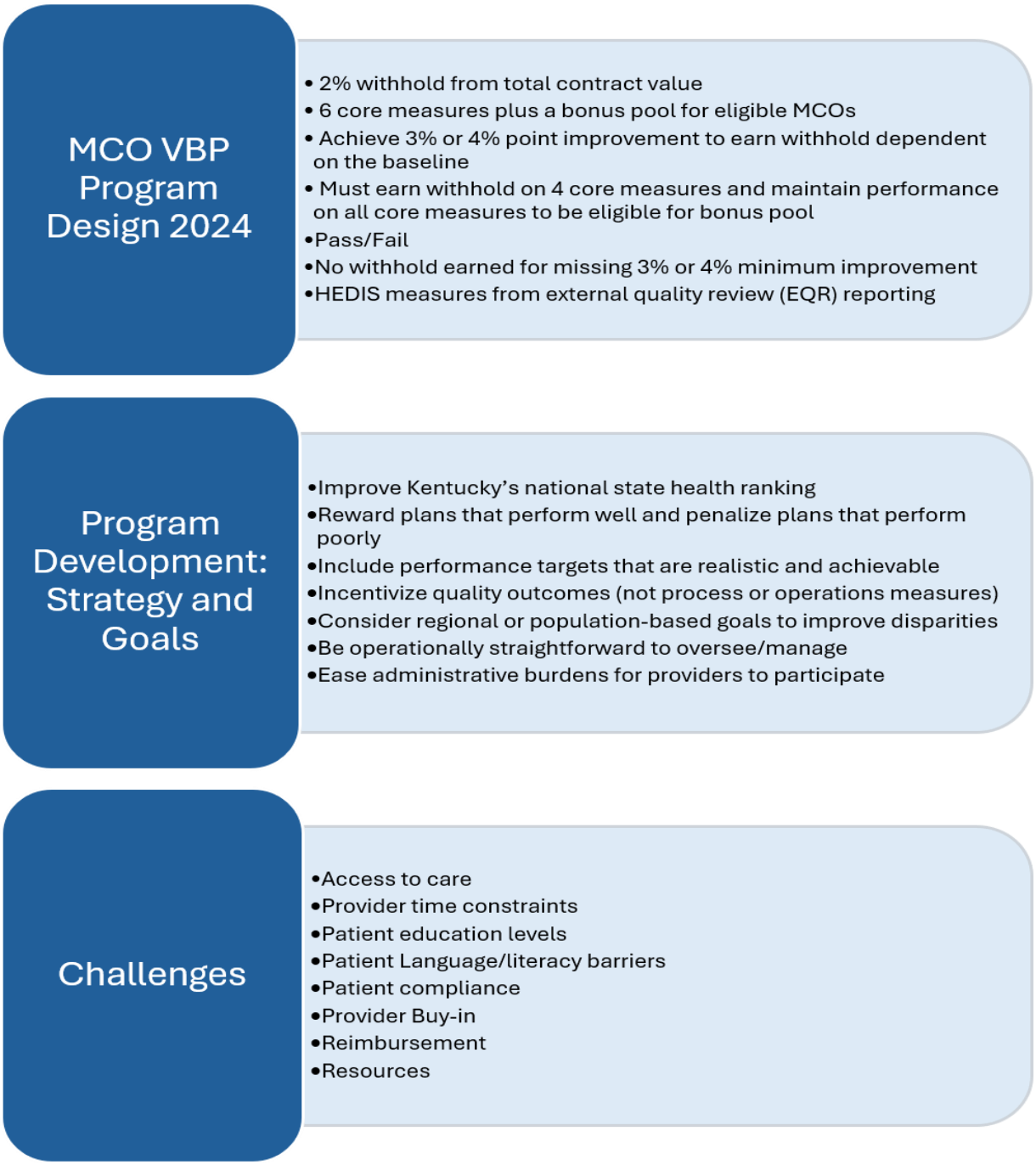
- *The goal from the 2019 Quality Strategy focused on SUD was broadened to a behavioral health-focused quality goal in the 2023 Quality Strategy*, with SUD included within the larger objectives. This approach exemplifies a more general population health approach, with its objectives and measures aimed at care coordination and integrated care. The 2026 Quality Strategy for Behavioral Health focuses on co-occurring, community-based treatment as well as expansion of pilot of Certified Community Behavioral Health Clinics (CCBHC). Six (6) additional CCBHCs on-boarded in January 2026 enhancing care coordination across the state.
- *The updated Quality Strategy continues to focus resources on objectives included in the 2023 Quality Strategy*. Of the measure rates in Goal 2 with data for both MY 2023 and MY 2024, there are opportunities to improve performance for the measures where lower values are better; this includes measures for Asthma Corticosteroid Pharmacotherapy (PCE), Plan All-Cause Readmissions (PCR) and the three Prevention Quality Indicator (PQI) measures.
- *The objectives in the preventative care category have been reduced* from the 2019 strategy to allocate more resources to higher priority issues: cancer screenings, adolescent wellness, and tobacco/nicotine cessation. The objectives for the latter are state-wide standardization and coordination of cessation programs for DMS of Public Health and all MCOs. Preventive care continues to be an area needing improvement in Kentucky.
- *DMS continues work to assure that all strategy measures are captured, stratified, and reported on a population health/demographic basis* to better understand barriers to access, which will in turn support health equity initiatives. Access to care was identified as the highest priority in 2022 key informant interviews. Stratification should provide insight into the relationship between the Quality Strategy and on-going health disparities.
- *The revised quality strategy reinforces the capture of metrics, characteristics, and performance of value-based contracting by all MCOs on a standardized basis.* Paying for the quality of care is a key priority across all partners. Generally, these initiatives consist of contracting that captures the metrics, demonstrate the characteristics, and enhancement to performance to maximize the Institute for Healthcare Improvement (IHI) Triple Aim such as value-based contracting. This revised strategy supports a foundation for policies, education, and initiatives for value-based care.
- In the revised Quality Strategy, *the special populations of pregnant persons and newborns are targeted with specific objectives and outcomes*. A second target population of "aging out" foster children is also identified. The 2026 Quality Strategy will continue to include fewer objectives associated with special populations, with the expectation that focusing resources will achieve outcome targets.
- A cross-cutting issue for the Quality Strategy, the well-received SDoH PIP concluded in state fiscal year (SFY) 2022. The Social Need Screening and Intervention (SNS-E) measure replaces the PIP SDoH quality measures in this updated version of the Quality Strategy.

3.2.1 Value-Based Payments (VBP)

The Kentucky Medicaid VBP Program started January 1, 2024. The VBP model aligns incentives for enrollees, providers, MCOs, and the Commonwealth to achieve Medicaid program goals in access, outcomes, quality of care, and savings in alignment with the 2023-2025 MCO Quality. Performance measures and related targets to be incentivized through the VBP program and the payment strategies are tied to achievement of the outcomes.

Figure 3 describes Kentucky Medicaid's VBP Program's design, development, and Challenges. Table 8 displays the results of VBP Measures for MY 2025. And Table 9 displays KY Medicaid's Proposed VBP Measures for MY 2026.

Figure 3: VBP Program Design, Development, and Challenges



VBP Program MY 2024 Result Summary

The Core and Bonus Measures had at least one MCO increase in performance, by at least 3 percentage points:

- All plans met 4 of the 5 Core Measures; United met all 5 Core Measures
- All plans met improvement targets for GSD, PPC, WCV, and IMA Combo 1
- 1 plan met the improvement target for CIS Combo 10

Four plans (Humana, Molina, United, and Wellcare) were eligible to participate in the Bonus Pool

- Humana met all 4 Bonus Measures
- All 4 plans met the improvement target for WCC
- Humana and United met the improvement target for FUA
- Humana, Molina, and Wellcare met the improvement target for BCS

(continued on next page)

Table 8: VBP Measures MY 2024 Results

Core Measures	MCO				
	ABHKY	Humana	Passport	UHC	WellCare
Glycemic Status Assessment for Patients with Diabetes (GSD)	66.67%	65.69%	52.31%	63.75%	68.61%
Postpartum Care (PPC): Postpartum Care	85.64%	81.48%	79.76%	83.70%	82.00%
Child and Adolescent Well Care Visits 3-21 years of age (WCV) sum of stratifications: Total	50.09%	51.25%	56.58%	48.90%	50.75%
Childhood Immunization Status (CIS-E): Combination 10	19.12%	24.16%	31.42%	26.13%	27.20%
Immunizations for Adolescents (IMA-E): Combination 2	28.96%	29.08%	34.81%	21.36%	27.20%
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)	0.78%	0.02%	3.10%	2.29%	1.22%
Food Intervention (Total)	41.22%	25.00%	0.75%	0.79%	9.58%
Housing Screening (Total)	2.53%	0.25%	3.17%	0.49%	1.31%
Housing Intervention (Total)	0.00%	0.00%	0.38%	0.00%	0.00%
Transportation Screening (Total)	1.80%	0.03%	3.05%	1.93%	1.66%
Transportation Intervention (Total)	0.00%	0.00%	0.41%	0.00%	0.67%
Bonus Pool Measures					
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)					
Blood Glucose Testing (Total)	55.96%	49.53%	52.56%	44.06%	50.60%
Cholesterol Testing (Total)	36.13%	33.78%	38.01%	25.74%	29.27%
Blood Glucose and Cholesterol Testing (Total)	34.93%	32.97%	36.09%	24.26%	28.41%
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): 7-Day - Total	32.30%	38.12%	29.34%	26.94%	29.27%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC): Counseling for Nutrition Total	73.72%	73.96%	66.67%	69.34%	70.56%
Breast Cancer Screening (BCS-E)	48.54%	50.68%	50.04%	49.70%	50.29%

Table 9: VBP Measures MY 2026

Core Measures
Glycemic Status Assessment for Patients with Diabetes (GSD): The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement period: Glycemic Status <8.0%.
Postpartum Care (PPC) Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7-84 days after delivery.
Child and Adolescent Well Care Visits 3-21 years of age (WCV) sum of stratifications - Total: The percentage of members 3-21 years of age who had one or more well-child visits with a PCP or an OB/GYN practitioner during the measurement year.
Immunization for Adolescents (IMA Combo 2): The percentage of adolescents 13 years of age who had one-dose of meningococcal vaccine, one-dose tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.
Breast Cancer Screening (BCS-E): The percentage of women 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.
Controlling Blood Pressure (CBP): The percentage of persons 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.
VBP Bonus Pool Measures
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): The percentage of children and adolescents 1-17 years of age with ongoing antipsychotic medication use who had metabolic testing during the year.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) Counseling for Nutrition Total: Percentage of children and adolescents 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of: • Body mass index (BMI) percentile documentation. • Counseling for nutrition. • Counseling for physical activity.
Childhood Immunization Status (CIS Combo 10): The percentage of children 2 years of age who had combination 10 vaccines by their second birthday.
Social Need Screening and Intervention (SNS-E): The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.
Follow-Up After Emergency Department Visit for Mental Illness (FUM) The percentage of emergency department (ED) visits for persons 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. The percentage of ED visits for which the person received follow-up within 7 days of the ED visit (8 total days).
Oral Evaluation, Dental Services (OED) The percentage of persons under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement period

3.3 Health Disparity Initiatives

Health equity is listed as the first of five priorities for the Kentucky Cabinet for Health and Family Services (CHFS) Strategic Plan. CHFS's mission is to be a fair and accessible organization providing programs, services, and supports that protect and promote the health and well-being of all Kentuckians. The operationalization of equity as a pillar within CHFS focuses on equitable care, equity data collection, and identification of social risk factors and mitigation. It includes advancing equity in hiring and procurement, utilization of racial equity tools to evaluate program design and impact, disaggregating data to uncover disparities in outcomes, and targeting campaigns to underserved populations to promote equitable access to services.

Equity is understood as providing fair and just outcomes for all individuals, regardless of their background, circumstances, or needs. It goes beyond equality by addressing the root causes of disparities and ensuring that resources, services, and opportunities are distributed in a way that accounts for differences in access, capacity, and barriers. DMS uses equity principles to guide its programs and policies, particularly in areas such as: healthcare access for low-income, underserved, and marginalized populations, program design that considers the unique needs of diverse communities, including rural, urban, and culturally specific populations, policy implementation that reduces systemic barriers to care, such as transportation, language, and cultural competence, and data-driven decision-making to identify and address disparities in health outcomes and service utilization.

The revised quality strategy treats health disparities as a cross-cutting issue. All measurements for the objectives will be reported on a sub-population basis by race, gender, age, ethnicity, and geography. A specific goal on the SDoH was added to the strategy based upon a successful PIP introduced under the 2019 Quality Strategy. PIPs include disparity analysis methodologies to identify susceptible populations and inform development of approaches to address health care inequities. MCO contracts will be updated to reflect the ongoing changes and increased focus on health equity, requiring that they be included in the MCO population health and quality programs.

Furthermore, the Kentucky MCO contract was updated to include language requiring all MCOs to obtain the National Committee for Quality Assurance (NCQA) Equity Accreditation. In 2026, NCQA Equity Accreditation was renamed to NCQA Health Outcomes Accreditation. This requires plans to identify and address barriers that prevent their members/patients from accessing high-quality care. Also in 2026, the NCQA Health Equity Plus Accreditation was re-named to Community-Focused Care Accreditation. This program assists healthcare organizations cultivate community-based partnerships to connect members/patients to non-medical and/or social needs resources. All five currently contracted MCO plans have achieved NCQA Health Equity Accreditation, meaning they have met rigorous requirements for the delivery of culturally appropriate care and QI interventions serving diverse populations.

To ensure all populations feel valued and supported, DMS has:

- Created a Member Language Access Guide in 2025. This guide has been posted and shared on the Member and Provider web pages on the DMS website. The guide provides information on how to access language services for members with an MCO.
- Created uniformed MCO Health Risk Assessments (HRA). Members should be screened at initial enrollment and annually thereafter. These assessments allow MCOs to identify specific needs for Medicaid members and offer services to improve health outcomes. The HRAs have

options for members to report race, ethnicity, language information, sexual orientation, and gender identification.

- Developed numerous reports to collect data on health-related information. The past few years, staff have worked to track MCO value added benefits utilization, maternal health care management and c-section rates, and more. The new reports create avenues for DMS to analyze the Medicaid population needs, utilization, and possible deserts of care.
- Targeted the Medicaid Provider Network. Ensuring the provider network lists are correct assists with improving member's access to equitable care.
- To assist with members receiving timely services, developed a Member Access to Care Form to help members report problems with getting an appointment to see a provider
    - When members complete this form, DMS is able to see if there is a problem with an MCOs provider network meeting requirements as outlined in their contract.
    - The link to this form can be found on the member page: Member Information - Cabinet for Health and Family Services.

MCOs implement a variety of initiatives, programs, and services to advance health equity and reduce disparities, including efforts related to maternal and perinatal care, preventive screenings, chronic condition management, behavioral health and wellness, and addressing social needs such as housing, food/nutritional support, transportation access, and language access. DMS has created a monthly report for the MCOs to share past and upcoming Community Events throughout Kentucky. DMS is learning about the impact of these events as staff engage with attendees and community partners. This report is analyzed to ensure the MCOs are reaching out to all communities and providing information needed for the members in the area.

Coordination of these activities with the Quality Strategy will be driven by insights provided by Quality Strategy and PIP objectives, results of Quality Initiatives and more refined population health measurements. For example, DMS has redesigned and streamlined the HRA utilized by all MCOs. The HRA incorporates standard questions from the PRAPARE assessment tool,_additional standardized SDoH questions, and stratified race, ethnicity, language (REL), sexual, orientation, and gender-identity questions (SOGI). All MCO's are required to achieve a 20% completion rate of HRAs based upon their plan's member enrollment. Quarterly reporting of the HRA data will provide insight for the DMS team regarding SDoH/HRSN for specific populations. Further, this reporting mechanism will produce self-reported data regarding language spoken in the household and other relevant population data indicating barriers or disparities.

Disability status for individuals applying for Medicaid utilizing the Kentucky Integrated Eligibility and Enrollment System (IEES) is established using the same criteria as the Social Security Administration to determine Supplemental Security Income (SSI) eligibility. If a field determination cannot be made and the individual is not potentially eligible for SSI, a referral to the Medical Review Team is submitted. Partnering internally with agencies, such as the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), DMS continues to explore further methodologies for collecting, evaluating, and measuring data specific to populations that self-identify or are determined eligible for Medicaid based on a disability status. Additional partnerships have allowed opportunities to update the Medicaid application to include an SDoH/Health-Related Social Needs (HRSN) screening assessment and adding a Google translator to the Kentucky Health Benefit Exchange (KYNECT) platform that allows individuals to select their primary language when completing the online Medicaid application. These tech-enabled solutions empower individuals and families with shared decision-making throughout the process.

Kentucky uses the Federal definition of Disability, which is reported to the State via the State Data Exchange (SDX). The Social Security Administration's definition of Disability can be found at How Do We Define Disability? | The Red Book | SSA and is defined as, "To meet our definition of disability, you must not be able to engage in any substantial gainful activity (SGA) because of a medically determinable physical or mental impairment(s) that is either:

- Expected to result in death; or
- Has lasted or is expected to last for a continuous period of at least 12 months".

Health equity initiatives remain a high priority across DMS and among stakeholders. In alignment with this priority, DMS participated in a SDoH state cohort learning collaborative in October 2022, which led to its involvement in the Medicaid Innovation Collaborative (MIC) beginning in 2023. The MIC focused on improving the health and well-being of Medicaid members by addressing health disparities in Kentucky through collaborative and technology-enabled strategies.

These updates include:

- **Kynect** resources is a place to find local programs and services. Through a partnership with United Way of Kentucky, Kynect resources provide a mobile-friendly, managed directory to connect Kentuckians to the help they need. Residents can find programs to help with nee ds such as food insecurity, housing and employment supports, support groups, health programs and family-centered help. Categories of help include: Housing; Food; Employment; Transportation; Health; Finances; Education; Mental Health and Addiction; and Legal services. Community Partners, state agencies and others use Kynect resources to connect residents to community programs and services[13].
- System enhancements have been made to the Kynect benefits and Kynect resources platforms to capture and analyze SDoH throughout the commonwealth. Medicaid members can complete a resource needs assessment during the Medicaid Application process. This helps to automatically connect applicants with additional resources available on Kynect resources. This project has allowed DMS to identify Medicaid members using Kynect resources and to monitor the critical needs of those members. All five MCOs have onboarded with the platform to assist with connecting members to community resources.
- Effective May 2026, there is a Medicaid Tile available on the Kynect resources platform for those looking for resources specific to Medicaid, including MCO Value Added Benefits. DMS will gather metrics on the utilization of the Medicaid Tile to measure impact. Recent reports suggest an increase in website activity due to the newly added information listed on Kynect.
- A future website enhancement includes adding non-emergency medical transportation information on the tile for easier navigation of the service.

Engagement through the MIC cohort has provided KY with the opportunity to learn through qualitative and quantitative research regarding barriers most impacting individuals when applying for or when participating in Medicaid programs in various state agencies. The utilization of diverse focus groups using a multilingual approach allowed for more inclusive feedback. KY respondents indicated access to resources was of significant importance for them. Creating innovative methods utilizing technology was also of significant importance for Medicaid members as a 'stigma' was often cited as a barrier when seeking resources or health related social needs in person.

[13] (Kentucky Cabinet for Health and Family Services n.d.)

According to insight provided by our research partners Goodwin and Simon, survey results identified two primary areas of concerns for Medicaid enrollees: Those include Category I *Food Insecurity and Care Navigation*; and Category II *Infrastructure Solutions*. The following table below, Table 10, provides more specific categories for the concerns identified by Medicaid enrollees and Medicaid eligible enrollees participating in the research study: (continued on the next page)

Table 10: Concerns Identified by Medicaid Enrollees

Category I Food & Nutrition Security	Category I Housing Affordability & Quality	Category I Economic Stability / Education & Employment	Category I Navigating / Coordinating Care, Resources, & Services	Category II Transportation Services	Category II Infrastructure & Data Tools
Not enough food	Increased cost of living	Access to quality employment	Education about access to provider care	Access to reliable/timely public transportation	SDoH/HRSN education for state health care plans and Medicaid program
Buy food or pay bills	Increased rent/housing instability	Access to skill- based training	Trusted relationships with person asking social needs questions	Reliable transportation to work, health appointments, or social activities	Infrastructure needs to connect people and resources
Healthy food options	Decreased affordable/quality housing options	Access to financial tools, resources, and education	Education about eligibility services and coverage	Costly vehicle repairs/older vehicles	Availability of information to care teams about SDoH/HRSN information
Stigma with accessing food programs such as Women, Infants, and Children (WIC) or Supplemental Nutrition Assistance Program (SNAP)	Navigating governmental housing assistance programs	Access to long-term self-sufficiency.	Prefer SME when sharing information about social needs	Coordination of transportation due to limited vehicles per household	Availability of information to community-based organizations and government organizations about SDoH/HRSN

Lessons learned from the year-long cohort suggest that providing tech-enabled solutions as a tool to address HRSN in Medicaid should be considered in future policy making decisions. The key takeaway for the 2023 MIC Cohort includes supporting HRSN data collection and sharing, helping health care and social service organizations coordinate to address Medicaid enrollee needs and providing HRSN supports as proposed.

The DMS team continues to address barriers to resources related to SDoH/HRSNs. DMS and the MCOs partnered with the Department for Community Based Services (DCBS) to enhance the Medicaid application, with Office of Data Analytics (ODA) to expand the reporting capabilities of the KYNECT resources platform, and with the United Way 211 Call Center to create a closed-loop referral process. DMS created the SDoH Dashboard by utilizing the enhanced reporting capabilities of KYNECT resources. The dashboard provides detailed information regarding critical social needs of Medicaid members reported on the KYNECT resources SDoH Assessment Critical needs and referrals sent to community partners are displayed by category, location, and level of vulnerability. Additionally, DMS has developed a monthly report by MCO containing the critical social needs reported by their members each month, and the unsuccessful referrals sent to community partners. This report assists MCOs with supporting their members and aids with providing resources for critical social needs that may be preventing Medicaid members from focusing on their health. The dashboard will continue to assist DMS and MCOs with targeting interventions for specific populations while various agencies work to improve community resources and partnerships.

In the Departments of Public Health (DPH), Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and DMS within CHFS, there are several programs, committees, and workgroups focused on health equity including the Health Equity Community of Practice initiative. This initiative is championed by a health equity representative from each department and division of the cabinet. One of the main objectives of the Health Equity Community of Practice is creating a Health Equity Action Plan across all departments. The plan includes goals and objectives from each division that are aimed at expanding the racial equity lens from both a micro and macro level to expose racial disparities and create accountability for improving health equity for all Kentuckians. In updating the 2023 Quality Strategy, representatives from these aforementioned departments served on the Interdisciplinary Team and assisted in coordinating CHFS activities with other partners, including MCOs and providers.

4.0 REVIEW AND EVALUATION OF THE CURRENT STRATEGY

Through oversight and direction by the Division of Quality and Population Health, DMS seeks to accelerate quality, value, and population health improvement in Kentucky by leveraging relationships with MCOs, health care provider organizations, Medicaid enrollees, families, and community partners. The Quality Strategy is central to this process.

The MCOs are required to maintain NCQA accreditation. NCQA provides a framework for essential QI and measurement. The MCOs are also required to submit a full set of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers & Systems (CAHPS) data annually. DMS contracts with Island Peer Review Organization (IPRO) as its External Quality Review Organization (EQRO). All contracts entered into with DMS (MCO's and EQRO) incorporate the requirements and language imposed under 42 CFR 438.

The quality strategy is focused on delivery system reforms, including efforts related to SUD, chronic disease management, and general managed care. QAPI programs currently in effect or recently

completed indicate a continued evolving partnership among MCOs, DMS, providers, and other partners. Refer to Table 13 PIPs and PIP Interventions for PIPs implemented and to Table 14 Quality of Care Focus Studies for focus studies conducted since implementation of the 2023 Quality Strategy. The strategy and various initiatives associated with it form the foundation for the proposed strategy in this document. A review and evaluation of the current strategy is provided in the following sections. The methodology used to review the current Quality Strategy consists of the following:

- The EQRO Technical and Comprehensive Reports for 2022 through 2026
- Review of Kentucky's performance for Core Measures
- Comparison to national benchmarks and peer states
- Interdisciplinary Team review of current strategy and suggestions for improvement
- Semi-structured interviews of key informants
- Review of MCO contracts

4.1 Summary Findings of Evaluation of the Quality Strategy

The goals and objectives for the current quality strategy are listed in Table 11 below.

Table 11: Goals and Objectives for the 2023 Quality Strategy

Objective and Description		Quality Measure	Statewide Performance (MY 2023)	Statewide Performance Target for Objective (MY 2026)
Goal 1: Improving enrollee health outcomes through improved screening, recognition, and treatment retention for individuals with behavioral health conditions.				
1.1	Increase treatment retention for those diagnosed with behavioral health disorders	1.1a.) Antidepressant Medication Management (AMM): Effective Acute Phase Treatment *AMM was retired for MY 2025	64.91%	60.34%
		Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment *AMM was retired for MY 2025	47.02%	41.49%
		1.1b.) Adherence to Antipsychotic Medication for Persons with Schizophrenia (SAA)	59.49%	61.01%
		1.1c.) Pharmacotherapy for Opioid Use Disorder Total (POD)	28.36%	38.39%
1.2	Improve the overall health outcomes of those with serious mental illness by minimizing risk and adverse impacts of medication treatment and increasing health screening.	1.2a.) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) *APM was retired for MY 2024	30.25%	32.15%
		Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) *Replaced APM beginning MY 2025	30.50%	To Be Determined
		1.2b.) Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	84.86%	83.35%
		1.2c.) Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	80.88%	80.00%
		1.2d.) Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	75.43%	75.75%
1.3	Decrease number of emergency department visits for persons with Opioid Use Disorder (OUD)	1.3a.) Emergency Department Utilization (EDU) Persons with a primary diagnosis of OUD with any ED visit	To Be Aggregated	To Be Determined
		1.3b.) Persons who have more than one ED visit for a primary diagnosis of OUD	To Be Aggregated	To Be Determined
		1.3c.) Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day (FUA)	37.56%	To Be Determined

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		1.3d.) Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day (FUA)	25.18%	To Be Determined
1.4	Increase utilization of psychosocial care for children on antipsychotics	1.5a.) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	66.92%	70.90%
Goal 2: Improve outcomes associated with people with the chronic diseases of DM, hypertension, COPD, and asthma.				
2.1	Promote evidence-based treatment for hypertension and type 2 diabetes and related complications	2.1a.) Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) - Good Control (HbA1c < 8) *HBD was retired MY 2024	59.00%	46.86%
		Glycemic Status Assessment for Patients with Diabetes (GSD) (hemoglobin A1c <8.0%) *Replaced HBD beginning MY 2025	59.00%	65.99%
		Blood Pressure Control for Patients with Diabetes (BPD)	68.11%	67.97%
		Eye Exam for Patients with Diabetes (EED)	53.23%	54.78%
		Kidney Health Evaluation for Patients with Diabetes (KED)	26.70%	24.20%
		2.1b.) Blood Pressure Control Measures (CBP)	61.02%	61.49%
		2.1c.) Readmission Rate (State Specific PCR-AD)	To Be Aggregated	To Be Determined
2.2	Promote evidence-based treatment for COPD and related complications	2.2a.) Spirometry Testing in Assessment and Diagnosis of COPD (SPR) *SPR was retired for MY 2024	22.58%	26.22%
		2.2b.) Pharmacotherapy Management of COPD Exacerbation (PCE):		
		• Systemic Corticosteroid	74.37%	72.97%
		• Bronchodilator	82.14%	81.10%
2.3	Promote evidence-based treatment for asthma in adolescent and COPD in the adult population	2.3a.) Asthma in Younger Adults Admission Rate (PQI 15-AD)	1.50	To Be Determined
		2.3b.) COPD and Asthma in Older Adults Admission Rate (PQI 05-AD)	To Be Aggregated	To Be Determined
Goal 3: Increase use of preventative services.				
3.1	Increase preventative cancer screenings among adults	3.4a.) Colorectal Cancer Screening (COL) *COL was retired for MY 2024	39.45%	18.50%
		Colorectal Cancer Screening (COL-E) *Replaced COL beginning MY 2025	38.63%	18.50%
		3.4b.) Cervical Cancer Screening (CCS) *CCS was retired for MY 2024	54.45%	62.65%
		Cervical Cancer Screening (CCS-E) *Replaced CCS beginning MY 2025	48.17%	62.65%
		3.4c.) Breast Cancer Screening (BCS)	N/A	N/A

		*BSC was retired for MY 2023		
		Breast Cancer Screening (BCS-E) *Replaced BCS beginning MY 2024	48.32%	52.75%
3.2	Increase childhood physical activity and counseling	3.2a.) Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC):		
		• Counseling for Nutrition Total	63.82%	58.82%
		• Counseling for Physical Activity Total	64.21%	56.33%
		• BMI (Body Mass Index) Percentile Total	83.47%	76.40%
3.3	Improve wellness visits to support healthy child development	3.3a.) Well-Child Visits in the First 30 Months of Life (W30):		
		• 0- 15 Months ≥ 6 Visits (W15)	63.91%	65.09%
		• W30: 16- 30 Months	69.64%	77.09%
		3.3b.) Child and Adolescent Well Care Visits 3-21 Years of Age (WCV):		
		• Aged 3-11 Years	55.83%	51.86%
		• Aged 12-17 Years	47.09%	43.34%
		• Aged 18-21 Years	22.89%	21.06%
		• Sum of Stratifications (Total)	47.99%	44.41%
		3.3c.) Childhood Immunization Status: Combination 10 (CIS) *CIS was retired for MY 2025	22.79%	36.41%
		Childhood Immunization Status: Combination 10 (CIS-E) *Replaced CIS beginning MY 2025	22.55%	To Be Determined
		3.3d.) Immunizations for Adolescents (IMA): Combination 2 *IMA was retired for MY 2025	26.75%	34.63%
		Immunizations for Adolescents (IMA-E): Combination 2 *Replaced IMA beginning MY 2025	26.95%	To Be Determined
3.4	Tobacco / Smoking Cessation	3.4a.) Kentucky Smoker Quitline DPH and MCO program coordination on measures:		
		• Members who use tobacco registered	To Be Aggregated	To Be Determined
		• Members who use tobacco engaged	To Be Aggregated	To Be Determined
		• Members who use tobacco complete program	To Be Aggregated	To Be Determined
		• Members who use tobacco success rate	To Be Aggregated	To Be Determined
Goal 4: Promote access to high-quality care and reduce unnecessary spending.				
4.1	Achieve collaborative relationships between providers & MCOs to provide	4.1a.) MCO Value Based Care (VBC) Data:		
		• Percent of providers under VBC	To Be Aggregated	To Be Determined
		• Percent of members attributed to providers under VBC	To Be Aggregated	To Be Determined

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	care strategies such as Value Based Care	• Percent of state identified quality metrics covered under VBC arrangements	To Be Aggregated	To Be Determined
		• Percent improvement of quality score	To Be Aggregated	To Be Determined
		4.1b.) Core measures for following cohorts:		
		• VBC providers	To Be Aggregated	To Be Determined
		• Non-VBC providers	To Be Aggregated	To Be Determined
		• Total membership	To Be Aggregated	To Be Determined
4.2	Access	4.2a.) Analyze state performance for all core measures based upon sub-populations of gender, race, age, and geography	To Be Aggregated	To Be Determined
		4.2b.) Covered lives with annual PCP visit Adults' Access to Preventive / Ambulatory Health Services (AAP)	80.96%	83.00%
		4.2c.) Telehealth Measures (New):		
		• Number of Telehealth Visits	To Be Aggregated	To Be Determined
		• Number of Telehealth Visits by Modality (Video, Audio)	To Be Aggregated	To Be Determined
Goal 5: Improve outcomes for identified special populations.				
5.1	Improve outcomes for pregnant moms and newborns	5.1a.) Prenatal and Postpartum Care (PPC):		
		• Timeliness of Prenatal Care	84.81%	86.80%
		• Postpartum Care	82.21%	81.53%
		5.1b.) Reduce Caesarian Section Rate:		
		• Primary C-section (CPT Code 59510)	To Be Aggregated	To Be Determined
		• Repeat C-section (CPT Code 59618)	To Be Aggregated	To Be Determined
5.2	Improve care coordination for children transitioning out of foster care (aging-out)	5.2a.) Well Child Visits 18-21 (WCV)	47.99%	44.41%
		5.2b.) Annual Dental Visit 2-20 years of age (ADV)	To Be Aggregated	To Be Determined
Goal 6: Improve assessment, referral, and follow-up for SDoH among the Medicaid members in Kentucky.				
6.1	Improve the quality of enrollee SDoH assessment by incorporating two assessment questions to the HRA to address social connectivity/ isolation	6.1a.) Percentage of new enrollees with a completed SDoH-Enhanced Health Risk Assessment (with at least two standardized questions to address the social connectivity/isolation domain)	To Be Reported From PIP[14]	To Be Determined

[14] (IPRO n.d.)

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6.2	Improve the rate of enrollee receipt of SDoH assessments	6.2a.)	Percentage of enrollees enrolled in case management with a comprehensive needs assessment (CNA) that assesses SDoH Domains of Social Connectivity/Isolation, as well as housing, food insecurity, other financial problems (e.g., clothing, phone, medication), and transportation	To Be Reported From PIP[15]	To Be Determined

[15] (IPRO n.d.)

The Fiscal Year (FY) 2025 Comprehensive Evaluation Summary: Commonwealth of Kentucky Strategy for Assessing and Improving the Quality of Managed Care Services, conducted by IPRO acting as the EQRO, reviewed the performance of the managed care plans relative to this strategy.[16]

The summary of the measurement and review of performance is presented below:

Goal 1: Improving enrollee health outcomes through improved screening, recognition, and treatment retention for individuals with behavioral health conditions.

Of the eleven HEDIS measure rates in Goal 1 with data for both MY 2022 and MY 2023, six measure rates showed improvement between MY 2022 and MY 2023. Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) showed the largest increases of 4.74% and 3.82%, respectively. Of the six measures that showed improvement, two did not meet the 2026 statewide performance target: Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. The next Quality Strategy update could set a higher target rate for ongoing improvement of the four measures that did meet the 2026 statewide performance target.

Other increases in measure rates for Goal 1 ranged from 1.78% for Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD) to 3.49% for Antidepressant Medication Management (AMM): Effective Acute Phase Treatment; however, only the latter (AMM-acute phase) exceeded the 2026 statewide performance target.

Opportunities for improvement are evident for the Pharmacotherapy for Opioid Use Disorder Total (POD) measure, which decreased by 12.36% from MY 2022 to MY 2023, and did not reach the target rate. MCOs reported the POD measure stratified by race and ethnicity. The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure decreased by 2.23%. The APM measure is a MY 2024 MCO VBP bonus pool measure. The Follow-up After Emergency Department visit for Alcohol and Other Drug dependence – 30 Day and 7-Day (FUA) measures decreased by 9.60% and 10.52%, respectively, and the MCOs report both of these measures stratified by race/ethnicity. To ensure valid and reliable reporting by using standardized measures, the FUA measures replace the initially proposed measure "Emergency department (ED) utilization for persons with a primary diagnosis of OUD and persons who have more than one ED visit for a primary diagnosis of OUD." The FUA-7 measure is a MY 2024 MCO VBP bonus pool measure.

For updates to the Statewide performance target rates for the FUA-30 and FUA-7 measures - refer to Table 12. Summary of the Proposed Quality Strategy Including Performance Targets.

Goal 2: Improve outcomes associated with people with the chronic diseases of DM, hypertension, COPD, and asthma.

Of the 8 HEDIS measure rates in Goal 2 with data for both MY 2022 and MY 2023, four measure rates showed improvement between MY 2022 and MY 2023. Hemoglobin A1c Control for Patients with Diabetes (HBD) - Good control (HbA1c < 8) and Spirometry Testing in Assessment and Diagnosis of COPD (SPR) showed the largest increases of 12.12% and 11.07%, respectively. Of note, the HEDIS SPR measure has been retired for MY 2024. For MY 2024, the HBD measure was revised to GSD. The next

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Quality Strategy update could set a new target rate for the GSD, Glycemic Status <8.0% measure is an MCO VBP core measure.

The measure rates for BPD - Blood Pressure and KED - Kidney also showed improvement with increases of 6.21% and 5.45%, respectively. These measures also exceeded the 2026 statewide performance target rates and, therefore, are candidates for setting higher target rates in the next Quality Strategy update for ongoing improvement. Higher target rates might also be considered for the Pharmacotherapy Management of COPD Exacerbation (PCE): Systemic Corticosteroid and Bronchodilator measures, as both have exceeded the 2026 statewide performance target (Table 2). However, the PCE-Bronchodilator measure also represents an opportunity for improvement, as the rate decreased by 1.26% from MY 2022 to MY 2023. An opportunity for improvement is most evident for the Blood Pressure Control Measure (CBP), which decreased by 2.77% from MY 2022 to MY 2023. The CBP measure is reported by MCOs stratified by race/ethnicity.

The PCR-AD, PQI 15-AD, and PQI 05-AD measures are first reported for MY 2023 without comparison data for MY 2022; therefore, percent change could not be calculated. Statewide performance target rates are to be determined pending the next Quality Strategy update.

Goal 3: Increase use of preventative services.

Of the 14 HEDIS measure rates in Goal 3, eleven measure rates were reported for both MY 2022 and MY 2023; of those eleven, ten measure rates showed improvement between MY 2022 and MY 2023. WCV 3–21 Years of Age: Aged 18–21 Years and Aged 12–17 Years showed the largest increases of 10.95% and 7.51%, respectively, and both exceeded the 2026 statewide performance target. The WCV measure for Aged 3–11 Years also exceeded the 2026 statewide performance target. Thus, all WCV measures are candidates for setting a higher statewide performance target rate in the next Quality Strategy update for ongoing improvement.

Other increases in measure rates for Goal 3 ranged from 2.26% for Immunizations for Adolescents (IMA) to 7.12% for WCV 3–21 Years of Age: Total. The HEDIS IMA-E and WCV Total measures are MCO value-based core measures. The HEDIS WCC measure for Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Counseling for Nutrition increased by 2.37%; this measure is an MCO VBP bonus pool measure.

There is an opportunity to improve the Childhood Immunization Status: Combination 10 (CIS) measure rate, which decreased by 12.78% from MY 2022 to MY 2023. The CIS-E Combo 10 measure is an MCO VBP core measure.

MCOs reported the following measures stratified by race/ethnicity: COL, to be retired for MY 2024 and COL-E; BCS-E; W30: 15-30 Months; WCV: Total; and Immunizations for Adolescents (IMA Combo 2 and IMA-E Combo 2). Per the MCO contract renewals for calendar years 2025-2026, the BCS-E measure is a MCO VBP bonus pool measure. The Colorectal Cancer Screening rates for the total COL and COL-E measures both exceeded the 2026 statewide performance target; therefore, a higher rate should be considered for the next Quality Strategy update. For MY 2025, NCQA is expanding the age range for the Breast Cancer Screening (BSC-E) measure from 50–74 years to 40–74 years. In the next Quality Strategy update, a new statewide performance target rate should be set based upon the MY 2025 rate to reflect the expanded eligible population.

The proposed measure to address Kentucky Smoker Quitline is planned to be aggregated in partnership with the DPH and MCOs and may be reported as early as in 2025 beginning with MY 2024 as the baseline measurement year in the Tobacco Cessation PIP for those MCOs with a Kentucky Quitline contract;

however, contracting barriers may limit the feasibility of this measure, and DMS is working in ongoing partnership with DPH to address these challenges. NCQA has approved a new measure for HEDIS MY 2026: Tobacco Use Screening and Cessation Intervention (TSC-E). The current HEDIS measure Medical Assistance with Smoking and Tobacco Use Cessation (MSC) will be retired for MY 2026. The Tobacco Cessation PIP Indicators 1a, 1b, and 1c are currently specified as each of the corresponding MSC measures, so will also be retired once the MSC measures are retired, and the new TSC-E measure will be reported as a PIP indicator starting MY 2026. The proposed TSC-E measure reports two rates:

1. The rate of persons 12 years of age and older who are screened for tobacco use.
2. The rate of persons who screen positive for tobacco use who receive tobacco cessation intervention, either through behavioral counseling for those 12 years and older or dispensed pharmacotherapy for those 18 and older.

Pending MCO reporting of the proposed TSC-E measure for MY 2026, DMS could consider inclusion of the TSC-E measure in the next Quality Strategy update.

Goal 4: Promote access to high-quality care and reduce unnecessary spending.

The Adults' Access to Preventive/Ambulatory Health Services (AAP) measure rate increased by 1.39% from MY 2022 to MY 2023. Of note, in the original Quality Strategy, Goal 4 proposed measures included measures of MCO value-based care (VBC) data. In the interviews with the MCOs, an update was provided on the MCO quality directors' work on proposed recommendations to the value-based program; specifically, the need for setting upper bound limits and aligning goals with national benchmarking to ensure sustainability. In the interview with DMS, an update was provided regarding their plan to assess MCO progress based on HEDIS data that includes the most recent measurement year for the VBP measures.

Goal 5: Improve outcomes for identified special populations.

The PPC: Postpartum Care measure rate increased by 5.18% from MY 2022 to MY 2023 and exceeded the 2026 statewide performance target; thus, setting a higher statewide performance target rate merits consideration for the next Quality Strategy update. Of note, this measure is an MCO VBP core measure.

There is an opportunity to improve the Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care measure rate, which decreased by 1.56% from MY 2022 to MY 2023.

Both PPC measures are NCQA-designated for stratified reporting by race/ethnicity in MY 2023 and were reported by MCOs for MY 2023 stratified by race/ethnicity.

The Low-Risk Cesarean Delivery (LRCD-CH) measure was calculated by CMS for MY 2023.

Goal 6: Improve assessment, referral, and follow-up for SDoH among the Medicaid members in Kentucky.

MY 2023 rates were not reported in the PIP reports for the two measures of SDoH as the final SDoH PIP year was for MY 2022. However, the MCOs do report non-standardized measures of SDoH assessments in the QM-03 report. The standardized SNS-E measure is a VBP core measure and was first reported by the MCOs for MY 2023. In the interviews conducted for the Comprehensive Evaluation, MCOs acknowledged that while progress is being made on reporting the SNS-E measure by working with providers to map Logical Observation Identifiers Names and Codes (LOINC) to the SNS-E measure, this process faces interoperability challenges, and initial numerators are small.

The evaluation involved a re-examination of the core measures used in the strategy due to limitations in the selected measures. A specific problem concerned the inclusion of measures requiring adjustment of specifications not allowed by the measure steward and measures without stewarded or standardized specifications. The measures had not been collected by the MCOs and were therefore unavailable for analysis.

This revised quality strategy continues to address these problems by focusing on HEDIS measures, and, where they are not appropriate or non-existent, getting MCO agreement on new measures, specifications and data collection before the strategy is implemented.

While progress was made in some measures, there remains substantial room for improvement in the health of Kentucky Medicaid beneficiaries.

As recommended in the Toolkit, the strategy proposed in this document provides a performance target for the measures associated with the objectives.

4.2 Partner Review of Existing Strategy and Input to Updated Strategy

In addition to a review by CMS, there were three primary sources of input to revising the 2023 Quality Strategy: The Interdisciplinary Team, semi-structured interviews of key informants, and public comments on the posted draft. The use of three different sources and methodologies provides for comprehensive perspectives. Results of interdisciplinary team reviews and key informant interviews extend to the updated Quality Strategy. Refer to Appendix B for a list of Interdisciplinary Team participants and to Appendix C for a table of Key Informant interview contributors.

The roster of the Interdisciplinary Team members is available in Appendix B. The Team met monthly. Sub-teams of subject-matter experts and volunteer members reviewed defined existing Quality Strategy Goals and Objectives and provided recommendations for the new strategy. The sub-teams met on a weekly or semi-weekly basis for 4 months. The work of these sub-teams, as reviewed and revised by the Interdisciplinary Team as a whole, are the basis for the goals, objectives, and measures for the proposed Quality Strategy.

The semi-structured interviews consisted of a formalized process. Key informants were identified across partners, primarily from the Medicaid TAC, consumer advocates and beneficiaries. An analysis of these interviews with key informants is available in Appendix C.

As required by regulation, the draft 2023 Quality Strategy update was posted on the DMS web site for 30 days. Public comments will be reviewed and incorporated into the draft 2026 Quality Strategy submitted to DMS as appropriate.

4.2.1 Summary of Key Informant Interviews

Key informants showed limited knowledge of the 2019 Quality Strategy but when reviewing the priority areas for the draft 2023 strategy concurred with their importance. Relative to the current strategy with priorities continued in the revised strategy, respondents agreed with the Interdisciplinary Team in prioritizing goals involving behavioral health, substance misuse, chronic diseases, and preventive care. Cross-cutting issues involve SDoH and health equity. A consistent observation was the need to coordinate the many initiatives and programs targeting disparities which are in process across partner organizations. Beneficiary engagement was identified as a priority area for both DMS and the MCOs.

The two areas of greatest discussion were access to care and system costs/reimbursement levels. Access issues concerned availability of providers accepting Medicaid and appointments, particularly for behavioral health care. Access to dentistry and optometry services were also identified as being acute issues. Network adequacy and geographic coverage in rural areas were also discussed by several key informants.

Reimbursement levels were discussed relative to system costs. The administrative burden of PAs was a major issue highlighted, as well as the complexity of dealing with multiple MCOs. The level of reimbursement and limitations on individual encounter complexity billing levels were identified as important barriers to access by discouraging provider participation.

There was overall agreement that payment and delivery reform are needed to drive Medicaid modernization in Kentucky. Value-based contracting and other outcome-based approaches were positively discussed.

There was also a general discussion of the limitations of HEDIS measures, but participants agreed that there are few alternatives at this point.

4.2.2 Summary of Public Comments

Fill in when Public Comments Completed

5.0 QUALITY STRATEGY UPDATE

The strategies supporting delivery reform and continuous QI for MCO in Kentucky represented in this Quality Strategy were developed from multiple sources of information and policies. These include:

- Existing strategies in CHFS and DMS, including delivery reform
- The 2023 Quality Strategy goals and objectives
- 2023 performance measurement outcomes
- Kentucky's state snapshot performance on the Core Set Measures compared to peers and national benchmarks
- External Quality Reports and Recommendations
- MCO QAPI programs
- Health disparity and health equity initiatives
- Enforcement activities, sanctions, and corrective plans for MCOs
- State demonstration and waiver programs
- State-directed payment data
- VBP Program evaluation
- Partner input

Six specific areas are addressed in the revised Quality Strategy:

1. Behavioral Health
2. Chronic Disease Management
3. Preventive Care
4. Delivery System Reform
5. Health Disparities
6. Social Determinants

A summary of the goals, objectives, and measures for these strategy areas is provided below in Table 12. An analysis and discussion for each is provided in the sections that follow.

Target improvement is based upon an assumption that each measure shows annual improvement from the 2024 Measurement Year baseline. DMS and IPRO collaborated to address EQRO recommendations in the SFY 2025 Comprehensive Evaluation Summary regarding quality measures exceeding MY 2026 statewide target rates established in the 2023 Quality Strategy. To align the revised Quality Strategy HEDIS measure target rates with the VBP model as required in Section 17.0 Quality Management and Outcomes of the MCO contract, strategies were identified to address the challenges of targeting rates for the Plan All-Cause Readmissions (PCR), COPD, and Asthma in Older Adults (PQI-05), Asthma in Younger Adults (PQI-15) and Low-Risk Cesarean Delivery (LRCD) measures. Method I - VBP method was used to set target rates for MY 2029 for all of the HEDIS rate measures, based initially upon MY 2024 baseline rates with VBP-assigned percentage points (PP) added to target MY 2026 rates, then annualized and extrapolated to MY 2029. MY 2026 target rates for the PQI, PCR, and LRCD measures utilize the Healthy People 2030 method of relative 10% improvement, with sensitivity analysis of 5% and 20%, and with comparisons to Quality Compass (QC) percentiles and CMS quartiles for benchmarking to guide setting a bold and feasible target rate (Method III).

The VBP method establishes a three (3) PP increase to set the MY 2026 rate in the absence of national benchmarks for the Social Needs Screening and Intervention (SNS-E) measure. Each of the Methods I and III incorporate standardized benchmarks (NCQA Quality Compass (QC), CMS Core Set quartiles,

and Healthy People 2030 respectively) useful to evaluate the extent that a target rate is bold and feasible, per CMS guidance. In addition, these three alternative methods utilize MY 2024 as the baseline rate, thus representing the most recent year of data and falling outside the COVID-19 emergency period that likely skewed rates during the original quality strategy MY 2020 baseline year.

New MY 2026 and MY 2029 target rates were set using Methods I and III. HEDIS measure data were derived from IPRO's review of the MCOs' HEDIS Final Audit Reports, while PQI measure results were obtained from the DMS Core Set Measure calculations. IPRO calculated the LRCD Child and Adult Core Set measure results using the Centers for Disease Control and Prevention (CDC) WONDER dataset for live births during 2023 and 2024. Method III was applied to the LRCD measures to address the lack of reported data and benchmarks for LRCD-CH (ages < 20 years) and LRCD-AD (ages > 20 years).

Quality Measures without standardized specifications or requiring adjustment from standardized specifications require further work to overcome challenges, aggregate baseline rates and determine SPT rates; e.g. for Telehealth; VBC; and Core Measures.

Table 12 displays the Summary of the Proposed Updated Quality Strategy including Performance Targets.

Table 12 :Summary of the Proposed Updated Quality Strategy including Performance Targets

Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
Goal 1: Improving enrollee health outcomes through improved screening, recognition and treatment retention for individuals with behavioral health conditions.			
1.1 Increase treatment retention for those diagnosed with behavioral health disorders	1.1a.) Adherence to Antipsychotic Medication for Persons with Schizophrenia (SAA)	62.02% (≥25th and <50th)	69.52%
	1.1b.) Pharmacotherapy for Opioid Use Disorder (POD): Total Rate	29.53% (≥50th and <75th)	34.53%
1.2 Improve the overall health outcomes of those with serious mental illness by minimizing risk and adverse impacts of medication treatment and increasing health screening	1.2a.) Metabolic Monitoring for Children and Adolescents on Antipsychotic Medications (APM-E): • Blood Glucose Testing, Total	52.51% (<25th)	62.51%
	• Cholesterol Testing Total	33.33% (≥25th and <50th)	40.83%
	• Blood Glucose and Cholesterol Testing, Total	32.19% (≥25th and <50th)	39.69%
	1.2b.) Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)	85.8% (≥75th and <90th)	88.30%
	1.2c.) Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia (SMC)	81.58% (≥50th and <75th)	86.58%
	1.2d.) Diabetes Monitoring for Persons with Diabetes and Schizophrenia (SMD)	77.81% (≥50th and <75th)	82.81%
1.3 Decrease number of emergency department visits for persons with OUD	1.3a.) Follow-up After Emergency Department Visits for Substance Use (FUA): • 30-day Follow-up, Total	43.18% (≥50th and <75th)	48.18%
	• 7-day Follow-up, Total	31.03% (≥50th and <75th)	36.03%
1.4 Increase utilization of psychosocial care for children on antipsychotics	1.4a.) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Total	66.97% (≥50th and <75th)	71.97%

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Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
1.5 Increase utilization of follow-up after emergency department visit for mental illness	1.5a.) Follow-up After Emergency Department Visit for Mental Illness (FUM): Total Rate, 7-day follow-up	39.78% (≥25th and <50th)	47.28%
Goal 2: Improve outcomes associated with people with the chronic diseases of DM, hypertension, COPD, and asthma.			
2.1 Promote evidence-based treatment for hypertension (HTN) and type 2 diabetes (T2DM) and related complications	2.1a.) Glycemic Status Assessment (GSD) <8%.	63.99% (≥50th and <75th)	68.99%
	2.1b.) Blood Pressure Control for Patients with Diabetes (BPD)	71.97% (≥50th and <75th)	76.97%
	2.1c.) Eye Exam for Patients with Diabetes (EED)	59.92% (≥50th and <75th)	64.92%
	2.1d.) Kidney Health Evaluation for Patients with Diabetes, Total (KED)	34.08% (<25th)	44.08%
	2.1e.) Controlling High Blood Pressure (CBP)	68.96% (≥50th and <75th)	73.96%
	2.1f.) Readmission Rate (State Specifications - PCR)	1.2283	1.0796
2.2 Promote evidence-based treatment for COPD and related complications	2.2a.) Pharmacotherapy Management of COPD Exacerbation (PCE): • Systemic Corticosteroid	73.28% (≥50th and <75th)	78.28%
	• Bronchodilator	82.81% (≥25th and <50th)	90.31%
2.3 Promote evidence-based treatment for asthma in adolescent and COPD in the adult population	2.3a.) Asthma in Younger Adults Admission Rate (PQI 15-AD)	1.5261	1.2208
	2.3b.) Follow-up After Acute and Urgent Care Visits for Asthma (AAF-E)	To Be Aggregated	To Be Determined
	2.3c.) COPD or Asthma in Older Adults Admission Rate (PQI 05-AD) 40-64 years of age	16.2993	13.0394
	2.3d.) Asthma in Older Adults Admission Rate (PQI 05-AD)	To Be Aggregated	To Be Determined

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Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
2.4 Increase follow-up care after emergency room visits for people with HTN, T2DM, asthma, COPD.	2.4a.) Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	To Be Aggregated	To Be Determined
Goal 3: Increase use of preventative services.			
3.1 Increase preventative cancer screenings and follow-up for abnormal results among adults	3.1a.) Colon Cancer Screening (COL-E)	43.55% (≥50th and <75th)	48.55%
	3.1b.) Cervical Cancer (CCS-E)	50% (≥25th and <50th)	57.5%
	3.1c.) Breast Cancer Screening (BCS-E)	50.42% (<25th)	60.42%
3.2 Increase childhood physical activity and counseling	3.2a.) Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC): • Counseling for Nutrition, Total	70.17% (≥25th and <50th)	77.67%
	• Counseling for Physical Activity, Total	69.05% (≥25th and <50th)	76.55%
	• BMI Percentile, Total	86.2% (≥50th and <75th)	91.20%
3.3 Increase pediatric oral health examination for persons under 21 years of age	3.3a.) Oral Evaluation, Dental Services, Total (OED)	46.54% (≥50th and <75th)	51.54%
	3.3b.) Topical Floride for Children (TFC)	10.03% (N/A)	To Be Determined
	3.3c.) Sealant Receipt on Permanent First Molars (SFM-CH)	To Be Aggregated	To Be Determined
3.4 Improve wellness visits to support healthy child development	3.4a.) Well-Child Visits in the first 30 months (W30) • 0-15 months > 6 visits (W15)15 months ≥ 6 visits (W15)	67.29% (≥50th and <75th)	72.29%
	• 16-30 months (W30)	72.87% (≥50th and <75th)	77.87%

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Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
	3.4b.) Child and Adolescent Well Care Visits 3-21 years of age (WCV) • 3-11 years	59.3% (≥25th and <50th)	66.80%
	• 12-17 years	50.93% (≥25th and <50th)	58.43%
	• 18-21 years	26% (<25th)	36.00%
	• Sum of Stratifications, Total	51.77% (≥25th and <50th)	59.27%
	3.4c.) Childhood Immunization Status (CIS-E Combo 10)	23.17% (≥25th and <50th)	30.67%
	3.4d.) Immunizations for Adolescents (IMA-E Combo 2)	29.18% (<25th)	39.18%
3.5 Tobacco/ Smoking Cessation	3.5a.) Tobacco Use Screening and Cessation Intervention (TSC-E) • Tobacco Use Screening	To Be Aggregated	To Be Determined
	• Cessation Intervention	To Be Aggregated	To Be Determined
Goal 4: Promote access to high-quality care and reduce unnecessary spending			
4.1 Achieve collaborative relationships between providers & MCOs to provide care strategies such as Value Based Care	4.1a.) MCO Value Based Care (VBC) Data: • Percent of Providers Under VBC	To Be Aggregated	To Be Determined
	• Percent of Members Attributed to Providers Under VBC	To Be Aggregated	To Be Determined
	• Percent of State Identified Quality Metrics Covered Under VBC Arrangements of state identified quality metrics covered under VBC arrangements	To Be Aggregated	To Be Determined
	• Percent Improvement of Quality Score	To Be Aggregated	To Be Determined
	4.1b.) Core measures for following cohorts: • VBC Providers	To Be Aggregated	To Be Determined

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Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
	• Non-VBC Providers	To Be Aggregated	To Be Determined
	• Total Membership	To Be Aggregated	To Be Determined
4.2 Access	4.2a.) Analyze state performance for all core measures based upon sub-populations of gender, race, age, and geography state performance for all core measures based upon sub- populations of gender, race, age, and geography	To Be Aggregated	To Be Determined
	4.2b.) Adult's Access to Preventive/Ambulatory Health Services (AAP) • Ages 20-44 years	81.15% (≥75th and <90th)	83.65%
	• Ages 45-64 years	86.77% (≥50th and <75th)	91.77%
	• Ages 65 years and older	88.89% (≥50th and <75th)	93.89%
	• Total Rate	83.28% (≥50th and <75th)	88.28%
Goal 5: Improve outcomes for identified special populations.			
5.1 Improve outcomes for pregnant moms and newborns	5.1a.) Prenatal and Postpartum Care (PPC): • Timeliness of Prenatal Care	85.60% (≥25th and <50th)	93.10%
	• Postpartum Care	83.08% (≥50th and <75th)	88.08%
	5.1b.) Reduce Cesarean Section Rate • Low-risk Cesarean Delivery: Under age 20 (LRCD-CH)	18.76%	17.78%
	• Low-risk Cesarean Delivery: Age 20 and Older (LRCD-AD)	26.65%	25.25%
	5.1c.) Prenatal and Postpartum Depression Screening and Follow-up: • Prenatal Depression Screening	18.97% (≥50th and <75th)	23.97%

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Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
	• Postpartum Depression Screening	6.94% (≥50th and <75th)	11.94%
	5.1d.) Prenatal and Postpartum Depression Screening and Follow-up:	52.18% (≥25th and <50th)	59.68% (≥25th and <50th)
	• Prenatal Follow-up on Positive Screen		
	• Postpartum Follow-up on Positive Screen	75.34% (≥50th and <75th)	80.34%
5.2 Improve care coordination for children transitioning out of foster care (aging-out)	5.2a.) Well Child Visits 18-21 (WCV)	26.00% (<25th)	31.00%
	Out of Home Care 15-17	66.69% (Ages 12-17; ≥75th and <90th)	69.19%
	Out of Home Care 18-21	43.90% (≥75th and <90th)	46.40%
	Former Foster Care 18-21	25.33% (<25th)	35.33%
	5.2b.) Oral Evaluation, Dental Services 15-20 (OED)		
	Out of Home Care 15-17	58.04% (Ages 15-20; >90th))	58.04%
	Out of Home Care 18-20	42.43% (Ages 15-20; ≥50th and <75th)	47.33
	Former Foster Care 18-20	26.15% (Ages 15-20; <25th)	36.15%
Goal 6: Improve assessment, referral and follow-up among the Medicaid members in Kentucky			
6.1 Increase SDoH screening and intervention among Medicaid enrollees	6.1a.) Social Need Screening and Intervention (SNS-E) The percentage of persons who were screened using prespecified instruments, or assessed by a provider, for unmet food, housing and transportation needs at least once during the measurement period, and the percentage of persons with a positive screen or identified need for food, housing or transportation who received an	1.63% (N/A)	To Be Determined

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Objective and Description	Quality Measure	Statewide Performance Baseline (MY 2024)	Statewide Performance Target for Objective (MY 2029)
	intervention corresponding to the positive screen or identified need within 30 days. • Food Screening (Total)		
	• Food Intervention (Total)	13.22% (N/A)	To Be Determined
	• Housing Screening (Total)	1.88% (N/A)	To Be Determined
	• Housing Intervention (Total)	0.13% (N/A)	To Be Determined
	• Transportation Screening (Total)	1.91% (N/A)	To Be Determined
	• Transportation Intervention (Total)	0.35% (N/A)	To Be Determined

5.1 Individuals with Behavioral Health Conditions

While the 2019 Quality Strategy focused specifically on issues of SUD within the domain of behavioral health, the 2023 strategy broadened the behavioral health related goals beyond SUD to include objectives targeting treatment retention and care coordination for individuals with SMI and the utilization of psycho- social treatments for adolescents on antipsychotic drugs. There is an overlap between the SUD and SMI populations, allowing for a potential positive interaction between the SMI and SUD objectives and their respective interventions.

Retired NCQA Antidepressant Medication Management measures are replaced with Prenatal and Postpartum Depression Screening and Follow-up measures under the Goal 5 Objective Improve outcomes for pregnant moms and newborns. The Follow-up After Emergency Department Visit for Substance Use (FUA) 7-day and 3-day measures were added with a new objective to this Goal to address challenges to collecting and reporting data for and to replace the Emergency Department Utilization (EDU) measure for persons with Opioid Use Disorder. The Follow-up After Emergency Department Visit for Mental Illness (FUM) 7-day measure was added to the updated Quality Strategy to align with addition of the measure to the Value Based Payment Program Bonus measures for MY 2026. An objective is added to increase utilization of follow-up after emergency department visit for mental illness. The APM-E measure was reported only as of MY 2024 with NCQA retirement of the APM measure and is a MY 2026 VBP Program Bonus Pool measure.

As highlighted in the population health section of this document, the continued impact of substance abuse across Kentucky is clear. In 2024, 8% of the Medicaid population received outpatient services for SUD and there were 5,819 newly initiated SUD diagnoses among beneficiaries each month. The proposed Quality Strategy continues to address targeted measures on pharmacotherapy for opioid use disorder and emergency department utilization.

The SUD Medicaid population is also being addressed by an 1115 Demonstration Waiver. This waiver targets improving access to care, increasing the use of evidence-based treatment for SUD/OUD, increasing provider capacity, and improving transition in care. CMS gave approval for TeamKY 1115 five-year waiver extension effective January 1, 2025-December 31, 2029. This waiver demonstration complements the Quality Strategy.

Four of the behavioral health measures focus on care coordination though the monitoring and screening for individuals with SMI and on children prescribed antipsychotic drugs. Increasing the use of first-line psychosocial care for children and adolescents on antipsychotics remains a targeted quality measure from the MY 2024 baseline of 66.97%.

The behavioral health services are recovery and resiliency focused. The MCOs work collaboratively with DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to assure that enrollees receive quality behavioral services. The MCOs and their providers use the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. They incorporate the core values that enrollees have the right to retain the fullest control possible over their behavior health treatment; that behavioral health services shall be responsive, organized and accessible to those who require behavioral healthcare; that the most normative care in the least restrictive setting will be provided in the community to the greatest extent possible. They measure enrollee satisfaction with services.

The MCOs maintain an emergency and crisis Behavioral Health Services Hotline that is staffed by trained personnel 24 hours a day throughout the Commonwealth. Face-to-face emergency services are

also available 24 hours a day, including the 988-crisis line, which was implemented in Kentucky in July of 2022. [17]

MCOs provide training to network PCPs on how to screen for and identify behavioral health disorders, the referral process for Behavioral Health Services, and clinical coordination requirements for those services.

5.2 Improve Outcomes Associated with Chronic Diseases

Kentucky continues to face major public health challenges in dealing with chronic diseases. In both the prevalence and treatment of diseases, Kentucky ranks near the bottom when compared to national benchmarks and other states. For example, Kentucky ranks 48th in the percentage of adults with three or more chronic diseases, 48th in COPD, 48th in cardiovascular disease, 44th in asthma, 46th in hypertension, 45th in obesity, and 48th in diabetes.

The proposed Quality Strategy continues to target the chronic diseases addressed in the 2019 Strategy as well as conditions added in the 2023 Quality Strategy: T2DM, hypertension, and COPD for adults, and admission rates for asthma-related diagnoses for children. In MY 2024, NCQA replaced the HBD measure with GSD, a MY 2024 and 2026 VBP Core measure, and retired the Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) measure. Controlling High Blood Pressure (CBP) continues to be a Core measure in MY 2026 VBP. The AAF-E measure, new in MY 2026, addresses the objective 2.3 to implement evidence-based treatment for adolescent asthma. The IPRO EQRO 2026 Comprehensive Evaluation Summary revealed MCOs recommended including the measure to replace the MY 2026 NCQA retired Asthma Medication Ratio (AMR) measure.

There are multiple ongoing activities and programs addressing chronic diseases throughout the Commonwealth. They are priorities for the Kentucky DPH, MCOs, and the federal government.

The EQRO conducted and DMS assisted with the coordination of the various activities underway. Pending findings of the four-year BCS PIP, the following new follow-up mammogram measures will tentatively be under consideration for addition to the Quality Strategy in upcoming years: Documented Assessment After Mammogram (DBM-E) and Follow-up After Abnormal Mammogram Assessment (FMA-E). The EQRO conducted the Disparities in Emergency Department Visits Among All KY MCO Adults and Follow-Up Care for Adults with Multiple High-Risk Chronic Conditions focus study. EQRO recommendations included adding the HEDIS FMC measure to MCO reporting requirements; conducting a PIP that aims to improve the HEDIS FMC rate; a focused collaborative with EDs that aims to improve follow-up for enrollees with multiple high-risk chronic and comorbid conditions discharged home from an ED visit for chest pain; and incorporating disparity analysis into the quality strategy by requiring MCOs to report ED visit data stratified by race and ethnicity.

5.3 Increase the Use of Preventative Services

Paralleling the goal of improving outcomes for chronic diseases is the goal of increasing preventative care. The proposed Strategy focuses on five areas: cancer screening, childhood activity levels, childhood wellness, childhood oral health, and tobacco cessation.

The cancer screening measures breast, cervical, and colon cancer are carried-forward from the 2019 and current quality strategies. Statewide performance in breast and cervical cancer is well below benchmarks. The Cervical Cancer Screening and Breast Cancer Screening measures were reported for MY 2023 and MY 2025 respectively as NCQA HEDIS Electronic Clinical Data System (ECDS) measures

[17] (Office of the Governor, Commonwealth of kentucky 2022)

only. BCS-E is a MY 2026 VBP Program Core measure & is reported in the DMS 4-year BCS PIP initiated in MY 2025 with expansion from age 50-74 to 40-74 years of age with two new follow-up mammogram measures: DBM-E and FMA-E. In MY 2024, NCQA required reporting for the ECDS COL measure only. The recently concluded COL PIP reported positive indicator results for expansion of age range to age 45 years and is monitored for sustainability.

The OED & TFC measures replaced the NCQA retired MY 2023 ADV measure in MY 2022. OED is a DMS MCO MY 2026 VBP Bonus measure. Both measures are reported in the DMS Pediatric Oral Health PIP concluded in MY 2025. Based on findings from the Oral Health PIP conducted in partnership with DPH, improving children's oral health will be prioritized for outcomes improvement with addition of OED, TFC and SFM-CH quality measures. Given the reported status of health and physical activities for children in Kentucky, the revised Quality Strategy carries forward measures for counseling and wellness visits from the 2023 Quality Strategy including the WCC Counseling for Nutrition Total MY 2026 VBP Bonus measure as well as the WCV MY 2026 VBP Core measure.

Effective in MY 2025, NCQA requires reporting for CIS-E and IMA-E with retirement of the CIS and IMA measures. CIS-E Combination 10 continues to be a DMS VBP Program Bonus measure in MY 2026. IMA-E continues to be a DMS MCO VBP Program Core measure in MY 2026. The Department is collaborating with DPH to implement a Tobacco Cessation PIP. Each of the MCOs has a unique tobacco/nicotine cessation program, as well, through DPH, Kentucky has a statewide program for tobacco/nicotine cessation, the Kentucky Smoker Quit line. The proposed Quality Strategy will continue to align these tobacco/nicotine cessation activities and, as part of a recently implemented Tobacco Cessation PIP, require that the MCOs each report similar data and that their data parallel those collected in the state program. Additionally, the new TSC-E measure replaces the four (4) measures in the current Quality Strategy and will be reported in the recently initiated Tobacco Cessation PIP.

In general, preventive care is directed by contract requirements for the MCOs. MCOs have programs and processes in place to address preventive healthcare needs of its population. MCOs conduct health screening assessments, including mental health and SUD screenings of new enrollees within ninety days of enrollment for the purpose of meeting the enrollees' health care needs. Collected information includes demographics, and current health and behavioral health status, which are used to determine enrollees' need for care management, disease management, behavioral health services, and any other health or community services.

5.4 Promote Access to High Quality Care and Reduce Unnecessary Spending

To meet the goals of promoting access to high quality care and reducing unnecessary spending on delivery, reform is required. In development of the 2023 Quality Strategy, Key informant interviews identified access to services as the major issue and priority for beneficiaries. Access to care is closely linked to disparities and health equity and is addressed in the Quality Strategy through continued refinement of reporting requirements. All Core measures will be reported by subpopulations. DMS and MCOs will collaborate to update current reporting to allow nuanced analysis of barriers to access in relation to the characteristics of disparities. This data will provide cross-cutting utility across the quality goals and better inform Medicaid policies.

The 2023 Quality Strategy included additional access measures tracking telehealth use and the number of beneficiaries with a primary care provider encounter. The primary care provider encounter measure was updated with the AAP measure.

Similarly, all partners identified migration to quality-based reimbursement, such as VBC, as critical to the evolution of Medicaid services. Refer to Section 3.2.1, Value-Based Payments, for updates of the

VBPs. MCOs are contractually required to offer value-based contracts, which are negotiated individually between the MCO and the provider organization. The quality strategy measures for the goal of reducing unnecessary spending through the use of payment reforms is focused on establishing baselines for the number, type (e.g., risk characteristics), and outcomes for Medicaid value-based contracting.

In addition, DMS will continue to work with MCOs to implement innovative value-based model(s) aimed at transitioning from a reimbursement model that rewards providers based on volume to a model that aligns payment incentives with quality, performance, and outcomes. Further, DMS will pursue additional managed care system reforms aimed at improving the efficiency and responsiveness of the current managed care delivery system.

Telehealth measures have been removed from the Access objective related to discontinuation of the Public Health Emergency (PHE) in May 2023.

5.5 Improve Outcomes for Identified Special Populations

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional conditions and who may require a broad range of primary, specialized medical, behavioral health, or related services. ISCHN have an increased need for healthcare or related services due to their conditions. As per the requirement of 42 C.F.R. 438.208, DMS has defined the following categories of individuals as ISHCN:

- Children in or receiving Foster Care or adoption assistance
- Blind/Disabled Children under age 19 and Related Populations eligible for SSI
- Adults over the age of 65
- Homeless (upon identification)
- Individuals with chronic physical health illnesses,
- Individuals with chronic behavioral health illnesses,
- Children receiving EPSDT, and/or
- Children receiving services in a Pediatric Prescribed Extended Care (PPEC) facility or unit.

MCOs have written policies and procedures in place which govern how enrollees with these multiple and complex physical and behavioral health care needs are screened, identified, treated, and supported. They assess each identified ISHCN enrollee in order to ascertain any ongoing special conditions that require a course of treatment or regular care monitoring. MCOs develop information and materials specific to the needs of the enrollee and distribute them to ISHCN enrollees, caregivers, parents or legal guardians, as appropriate. This information includes health educational material as appropriate to assist ISHCN or caregivers in understanding the chronic condition. MCOs produce a treatment plan for enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring.

MCOs develop practice guidelines and other criteria that consider the needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. In addition, because DMS covers more than half of all births in Kentucky, DMS, in partnership with MCOs and other Cabinet Departments, has several programs aimed at improving outcomes for pregnant mothers, infants, and children. The DPH operated Kentucky Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program that supports families through pregnancy and the first two years of life. The Kentucky Early Intervention System is a statewide program that provides interventional services to families with children with developmental disabilities from birth to age 3. DMS and MCOs also help support children and families through EPSDT. In Kentucky, EPSDT is divided into two components: EPSDT Screenings and EPSDT Special Services. The

EPSDT Screening Program provides routine physical exams or well-child check-ups for eligible children at specified ages.

The Postpartum Care measure continues to be a VBP Core measure in MY 2026. To support improvements of outcomes for pregnant moms and newborns and related to DMS participation in the Maternal Health Affinity Group for Hypertension and Mental Health/SUD as well as Population Health updates of Health Risk Assessment tools, the following perinatal depression screening and follow-up measures from the NCQA suite of behavioral health measures replace the retired AMM measure: MY 2020 & MY 2021 Prenatal Depression Screening and Follow-Up (PND-E) Post-Partum Depression Screening and Follow-Up (PDS-E). The NCQA Annual Dental Visit (ADV) was retired by NCQA in MY 2023. Now OED dental services is reported to replace the ADV measure for the Aetna Better Health of Kentucky foster care enrollees in Out of Home Care & Former Foster Care populations, both accounted for in transition from foster care.

Children are checked early for medical problems through preventive check-ups; growth and development assessments; vision, hearing, and tooth exams; immunizations; and laboratory tests. If conditions are discovered via screening, additional services and support may be available.

The Supporting Kentucky Youth (SKY) program is the Commonwealth's Medicaid risk-based managed care delivery program for Foster Care Enrollees and Dually Committed Youth (DCBS and Department of Juvenile Justice (DJJ)) through a single MCO, Aetna Better Health of Kentucky. Former Foster Care Youth Enrollees, Adoption Assistance Enrollees, and DJJ Youth may opt to participate as well. A care coordination team is assigned to each SKY beneficiary who ensures access to primary care, behavioral health services, dental care, specialty care, wraparound services, and social support services, with level-of-care management tailored to meet individual needs.

Led by DBHDID, with support from DMS and MCOs, the Kentucky Opioid Response Effort (KORE) is designed to be a comprehensive targeted response to Kentucky's opioid crisis by expanding access to a full continuum of high quality, evidence-based opioid prevention, treatment, recovery, and harm reduction services and supports in high-risk geographic regions of the state. KORE's target populations include persons who have survived an opioid-related overdose, those pregnant or parenting, justice-involved individuals, children, transition-age youth, and families.

Objectives targeting specific special populations are included in the updated proposed quality strategy. The greatest concerns are for improving outcomes for pregnancy and newborns and for improving care coordination for children transitioning out of foster care.

Kentucky lags national benchmarks in pre-natal and post-partum care; therefore, these basic services have been targeted for improvement. Kentucky also ranks in the bottom quartile in the number of Cesarean births. While not supported by a HEDIS measure, the Quality Strategy is working through multiple initiatives to address low risk Cesarean Delivery as well as tracking the Child and Adult Core Set Low-risk Cesarean Delivery (LRCD) measures. This is designed to support CMS initiatives aimed at low-risk Cesarean delivery to improve outcomes and reduce disparities.[18]

Improving care coordination for children transitioning out of foster care is also an objective for special populations. While aging out of foster care, adolescents risk falling out of Medicaid coverage or potentially experiencing care discontinuities. The measures focus on tracking and improving well-child visits and annual oral health evaluations for this cohort.

[18] (Centers for Medicare and Medicaid services n.d.)

5.6 Improve Assessment Referral and Follow-up for SDoH for Beneficiaries

DMS recognizes the cross-cutting importance of social determinants to the quality of service and outcomes for Medicaid beneficiaries. During SFY 2023, DMS and the MCOs concluded a PIP focused on social determinants, *Improving Assessment, Referral, and Follow-up for Social Determinants of Health*. As a 2026 VBP measure, the Social Needs Screening and Intervention ECDS measure replaces the SDoH connectivity and social isolation measures reported in the completed SDoH PIP. The SNS-E measure was incorporated in MY 2024 VBP as a Core Measure and is now a MY 2026 VBP Bonus measure.

6.0 CROSS CUTTING-CONSIDERATIONS AND THE QUALITY STRATEGY

6.1 Quality Measure Alignment with Child and Adult Core Set Measures

Kentucky's performance on the Child and Adult Core set measures was used in developing the 2019 Quality Strategy in two ways. The first was to identify areas of focus and improvement through results and comparisons to national benchmarks and other states. The second was to align the Quality Strategy measures as closely as possible to Core measures. The goals of increasing value-based care, tobacco/nicotine cessation activities, and the use of telehealth are not directly related to HEDIS outcome measures. However, they have been deemed important activities in the Commonwealth, and their measurement is central to the alignment and coordination of activities. As such, DMS will continue work to determine benchmarks in Kentucky beginning with the update of the Tobacco Cessation PIP measures to the new HEDIS MY 2026 NCQA Tobacco Cessation and Screening measure.

The SDoH and colon cancer screening goals carried forward measurements from PIPs. The colon cancer PIP anticipated and aligned with the NCQA colon cancer screening measure age range expansion. Cesarean-Section rate measures are updated with Low-risk Cesarean Delivery Child (LRCD-CH) and Adult (LRCD-AD) Core Set measures and will complement other federal initiatives targeting this area.

Overall, there were 56 measures reported, including 34 measures with rates for both MY 2023 and MY 2022 and change in rates calculated. Of the 34 measures with change in rates calculated, 23 (67.6%) showed improvement in rates between MY 2022 and MY 2023, while the other measures (32.4%) did not. Refer to p.7 and Table 2 of the KY FY 2025 Comprehensive Evaluation Summary Final July 2025 report[19].

As indicated by Core Measure performance, there continues to be an opportunity for improvement. DMS and the various partner oversight initiatives will continue to track performance on the targeted quality measures as well as Kentucky's overall performance in the Core Measure set.

6.2 Alignment with Other Managed Care Tools

The MCO Quality Strategy provides a central organizing tenet for DMS. As described in this document, this includes driving an alignment within a range of managed care tools including population-health-focused delivery models, risk and VBP models, interventions including PIPs and QAPI programs, coordination with public health and other initiatives within CHFS, and oversight activities.

6.3 Quality Assurance and Performance Improvement (QAPI) Activities

QAPI activities by the MCOs are monitored and reviewed for compliance with state and federal regulations by the EQRO. All five MCOs achieved 100% compliance in 8 of the 15 federal standard

[19] (IPRO 2025)

domains under Title 42 CFR § 438-Managed Care including Confidentiality; Subcontractual relationships and delegation; Practice guidelines; Health information systems; QAPI program; Program Integrity; Emergency and post-stabilization services; and Marketing activities. At the MCO level, Aetna, Humana, Passport, and WellCare all received 100.00% compliance for 13 domains. None of the other state citation standards received 100.00% compliance from all five MCOs, however, WellCare did receive 100% compliance for all three domains. MCOs are required to submit a quarterly report concerning quality-related QAPI activities. All the areas and reported measures are derived from the current Quality Strategy. This ensures a high degree of coordination between DMS and the MCOs driven by the Quality Strategy.

The MCO shall implement and operate a comprehensive QAPI Program in compliance with 42 C.F.R. 438.330 that focuses on health outcomes, health improvement, and HRSN. The QAPI program shall assess, monitor, evaluate, and improve the quality of care provided to Enrollees

The QAPI program shall include:

Collecting and submitting to the DMS performance measurement data that enables the Department to calculate performance on required measures, including indication of progress on measures and related outcomes.

6.3.1 Performance Improvement Project (PIPs) and PIP Interventions

PIPs are a primary vehicle for assessing and improving the processes and outcomes of healthcare provided by an MCO. During the period 2023– 2025, four PIPs were completed or initiated. These PIPs are summarized in Table 13. All PIPs are subject to review by the EQRO in the annual technical report and are assessed for:

1. Assessment of the study methodology
2. Verification of the PIP study findings
3. Evaluation of the overall validity and reliability of study results.

Measures from the four PIPs undertaken under the 2023 Quality Strategy have been used as objectives and measures for the proposed Quality Strategy: Colorectal Cancer Screening, Pediatric Oral Health and Breast Cancer Screening and Follow-up, and Tobacco Cessation Services PIPs. Table 13 includes a Summary of PIPs conducted under implementation of the 2023 Quality Strategy.

The MCO shall comply with 42 C.F.R. 438.330(d) to conduct-PIPs that focus on both clinical and non-clinical areas.

PIPs shall include the following elements:

A. Measurement of performance using objective quality indicators and measures and minimum performance levels as defined collaboratively by the DMS, the EQRO, and MCO prior to the commencement of each PIP.
B. Implementation of interventions to achieve improvement in the access to and quality of care

Table 13 :PIPs and PIP Interventions

PIP: Improving Colorectal Cancer Screening (January 1, 2021-December 31, 2023)	
PIP AIMs	**PIP Interventions**
Improve the rate of early screening for colorectal cancer among eligible enrollees aged 45-50 years	• Home Test Intervention for Early Colorectal Cancer (CRC) Screening: Identify enrollees aged 45- 49 years who have not been screened for colorectal cancer by creating a member gap report and conducting direct member outreach with education and offer for mailed Fecal Immunochemical Test (FIT) or Guaiac Fecal Occult Blood Test (gFOBT) home test, as well as addressing any concerns about out-of-pocket costs, with corresponding provider education. • Organize the Enrollees Aged 45-49 years Eligible for Early Screening member gap report by Care Manager/ Care Coordinator/Community Health Outreach Worker (CM/CC/CHOW). • Conduct direct member outreach with education and offer for mailed FIT or gFOBT home test • Organize the Enrollees Aged 45-49 years Eligible for Early Screening member gap report by PCP for distribution to PCPs. • Conduct direct provider outreach with education about American Cancer Society (ACS) and United States Preventive Services Task Force (USPSTF) recommendations for CRC screening starting at 45 years of age, as well as the mailed FIT or gFOBT home test benefit
PIP: Improving Access to Oral Health Services (January 1, 2023-December 31, 2025)	
PIP AIMs	**PIP Interventions**
1. Improve access to topical fluoride for children ages 1-4 years 2. Improve access to oral evaluation dental services for enrollees ages < 21 years 3. Improve access to dental sealants for children ages 6-9 years 4. Improve access to dental sealants for children ages 10-14 years	• Develop and distribute gaps-in-care reports for topical fluoride receipt to PCPs; develop and distribute gaps-in-care reports for oral evaluation receipt to dental providers; and develop and distribute gaps-in-care reports for dental sealant receipt to dental providers; each of these three interventions are to be provided with corresponding provider education regarding enrollee benefits and evidence-based care. • Develop and implement innovative approaches to dental provider enrollment and participation in geographic dental health provider shortage areas (DHPSAs) and/or alternative approaches to increase access for enrollees residing in DHPSAs (i.e., Fulton County, Hickman County, McCreary County, and Martin County). • Educate PCPs about how they and their clinical staff can apply fluoride varnish in their offices, as well as how to receive reimbursement. Link PCPs to training through the Kentucky Oral Health Program. • Collaborate with the Kentucky DPH and consult with the DCBS to identify best practices for ensuring enrollee access to pediatric oral health care, for example, establishing a dental home. Conduct enhanced member outreach for education and referral for pediatric oral health care. • Develop tailored and targeted interventions to address barriers specific to vulnerable populations, e.g., SDoH issues, children with special health care needs (CSHCN), DHPSA residents, racial/ethnic disparity subpopulations.

PIP: Improving Delivery of Tobacco Cessation Services (January 1, 2024-December 31, 2026)	
PIP AIMs	**PIP Interventions**
1. Medical Assistance with Smoking and Tobacco Cessation: a. Advising individuals that smoke and/or use tobacco products to quit b. Discussing Cessation Medications c. Discussing Cessation Strategies 2. Pharmaceutical Treatment for Adults 3. Cessation Counseling for Adults 4. Combination Pharmaceutical and Counseling for Adults 5. Cessation Counseling for Adolescents 6. Smoking Abstinence-Adults 7. KY Quitline specific tobacco cessation program adult enrollment	• Health Risk Assessment - Adults and Adolescents: Identify enrollees who use tobacco, educate about tobacco cessation benefit or other evidence-based cessation program and offer referral to KY Quitline. • CM/CC - Adults: Create a gaps-in-care report for tobacco users who did not receive smoking cessation treatment. • Conduct CM/CC outreach for member education on smoking cessation benefits. • Refer adults to PCP or Behavioral Health (BH)provider for treatment evaluation. • Provider Education (Adult and Adolescent care providers): Create a PCP-specific gaps-in-care report that lists each PCP's patients who did not receive smoking cessation for adults and adolescents, and distribute to PCPs, with education on the smoking cessation benefits, the KY Quitline referral process, and The CDC protocol for identifying and treating patients for tobacco cessation. • Public Health Education Campaigns for Adolescents • Certified Community Health Worker (CHW) KY Quitline referral
PIP: Improving Access to Breast Cancer Screening (January 1, 2024- December 31, 2027)	
PIP AIMs	**PIP Interventions**
1. Improve access to Breast Cancer Screening for eligible enrollees between the ages of 40-49 years 2. Improve access to Breast Cancer Screening for eligible enrollees between the ages of 50-74 years 3. Documented Assessment after Mammogram, ages 40- 74 4. Follow-Up After Abnormal Mammogram Assessment, ages 40-74	• Patient navigation is an evidence-based strategy to help enrollees overcome barriers to accessing breast cancer screenings. ○ Appointment scheduling and arranging alternative screening sites or hours ○ Providing member reminders ○ Coordination of transportation services, translation services, or assistance with childcare • Individual or group enrollee education • Reducing enrollee out-of-pocket costs • Improved provider screening and feedback

6.3.2 Quality of Care Focused Studies

In coordination with DMS and the EQRO, the MCOs are engaged in quality focus reports. These reports allow for the comparison of activities and performance across the MCOs, inform Medicaid policies, and identify the potential for managed care interventions to improve access, utilization, and quality of care. Table 14 provides a summary of focused studies since the implementation of the 2023 Quality Strategy.

These studies were used to inform and develop the proposed Quality Strategy including the objectives and measures. Two of the focused studies resulted in PIPs, Access to Pediatric Oral Health Care Services and Disparities in B, both of which used measures originally used in the study for the Quality Strategy. (Continued on next page)

Table 14:Quality of Care Focused Studies

Focus Study	Date Completed	Objectives
Community Health Worker (CHW) Utilization	2026	1. **Objective #1 –** MCO-employed CHW Services: Profile Kentucky MCO enrollee receipt of MCO-employed CHW services, including health system navigation and resource coordination; health education, promotion, and coaching for preventive care; facilitation of a care plan intervention; and SDoH referral and follow-up. The measurement period begins January 1, 2025, to include only those managed care plans serving Kentucky MCO enrollees starting January 1, 2025. • Eligible population: All MCO enrollees in each MCO care management information system, as identified by each MCO in accordance with the study methodology. • Measurement period: 1/1/25–6/30/25. 2. **Objective #2 –** Provider-billed CHW Profile Kentucky MCO enrollee claims for CHW services billed by providers, by provider type. • Eligible population: All MCO enrollees with claims for the provider types that may bill for CHW services. • Measurement period: 1/1/25–6/30/25.
Disparities in Access to Continuous Glucose Monitoring (CGM)	2026	1. **Objective #1 –** Evaluate disparities in the outcome of CGM access and risk factors for lack of CGM access during the measurement period from January 1, 2025, to June 30, 2025, by demographic enrollee characteristics (e.g., geographic area of residence, race/ethnicity, age group); clinical characteristics (e.g., T1DM; T2DM; DM in pregnancy, childbirth, and the puerperium; gestational DM with and without insulin dependence; multiple hypoglycemic events; alcohol use disorder; drug use disorder; serious mental illness; cognitive impairment; chronic kidney disease); SDoH; e.g., housing issues, food insecurity issues, adverse childhood experiences [ACEs]); and health care system-related enrollee characteristics (e.g., MCO of enrollment, continuous enrollment, PCP visits, endocrinologist/diabetologist visits). Both CGM device and supply claims were utilized to include both enrollees with current CGM device access and enrollees with prior CGM device access as supported by current requests for CGM supplies. 2. **Objective #2 –** Evaluate disparities in CGM device PA approvals, denials, and appeals upheld by MCO and MedImpact® (the Kentucky pharmacy benefits manager) from January 1, 2025, to June 30, 2025, with subset analysis by clinical categories, to include T1DM; T2DM; DM during pregnancy, gestational diabetes with and without insulin dependence; and enrollees with multiple hypoglycemic events. CGM devices may be accessed by Kentucky MCO enrollees either through medical claims filed directly with each MCO or through pharmacy claims filed through MedImpact. Because PA processes are conducted separately by each MCO and by MedImpact, PA denials were evaluated separately for each MCO and MedImpact. This analysis was restricted to PA requests specific to CGM devices to specifically address access to CGM devices and to provide the universe from which to sample enrollees with CGM device PA denials. **Objective #3 –** Identify the reasons for PA denials for CGM devices by MCO and MedImpact. This qualitative analysis aggregated PA CGM device denial reasons into meaningful categories to provide insights into possible opportunities for improving access.

Focus Study	Date Completed	Objectives
Disparities in Emergency Department Visits Among All KY MCO Adults and Follow-Up Care for Adults with Multiple High-Risk Chronic Conditions[1]	2025	1. **Objective #1a** - Among all adult Kentucky MCO enrollees, the focus study evaluated disparities in the outcome of any ED visits during the period from January 1, 2023–December 24, 2023. Disparities were evaluated using the chi-square test for association 2. **Objective #1b** - Among all adult Kentucky MCO enrollees, the focus study quantified risk factors for any ED visits during the period from January 1, 2023–December 24, 2023. Enrollee high-risk clinical conditions included those specified in the HEDIS Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) measure (COPD, asthma, Alzheimer's disease and related disorders, Chronic Kidney Disease (CKD), depression, heart failure, Myocardial Infarction (MI), atrial fibrillation, and stroke and TIA). For this analysis, the high-risk clinical conditions were not restricted to those occurring prior to the ED visit in order to include enrollees with these high-risk conditions without an ED visit. Risk or protective factors were quantified using multiple logistic regression statistical analysis. The following clinical conditions were evaluated: diabetes, hypertensive disorders, malignant neoplasms, Alcohol and Other Drugs (AOD)/SUD, and SMI other than depression (i.e., schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, and post-traumatic stress disorder [PTSD]). To minimize multicollinearity from using two variables that both measure enrollee county of residence, county-based variables (i.e., urban/rural/Appalachian county of residence versus county health rankings) were analyzed in separate models. In addition, diagnosis-based variables (i.e., FMC high-risk chronic conditions, grouped versus individual chronic conditions) were analyzed in statistical models separate from the individual FMC conditions. FMC groupings included enrollees with none of the FMC chronic conditions; enrollees with one behavioral health FMC condition, only; enrollees with one physical health FMC condition, only; enrollees with multiple FMC chronic conditions, all physical health; enrollees with multiple FMC chronic conditions, all behavioral health; and enrollees with multiple FMC chronic conditions, both physical health and behavioral health 3. **Objective #2a** -Among Kentucky MCO enrollees with multiple chronic conditions (COPD, asthma, Alzheimer's disease and related disorders, CKD, depression, heart failure, MI, atrial fibrillation, and stroke and TIA) prior to a treat-and release ED visit, the focus study evaluated disparities in receipt of follow-up visit within 7 days of the first ED visit that met the FMC measure criteria. Disparities were evaluated using the chi-square test for association. 4. **Objective #2b** - Among Kentucky MCO enrollees with multiple high-risk chronic conditions prior to a treat-and-release ED visit, the focus study quantified risk factors for nonreceipt of a follow-up visit within 7 days of the ED visit. If the enrollee had multiple ED visits, the first ED visit that met the FMC criteria was used for the analysis. Risk or protective factors were quantified using multiple logistic regression statistical analysis. To minimize multicollinearity, county-based variables (i.e., urban/rural/Appalachian county of residence versus county health rankings) were analyzed in separate multiple logistic regression models. In addition, FMC high-risk chronic conditions that were grouped versus individual chronic conditions were analyzed in separate

Focus Study	Date Completed	Objectives
		multiple logistic regression models. FMC high-risk condition groupings included enrollees with multiple physical health conditions, only; enrollees with multiple behavioral health conditions, only; and enrollees with multiple physical and behavioral health conditions. Again, multicollinearity was minimized by not counting enrollees with the same conditions twice in the same multiple logistic regression model. 5. **Objective #2c** - Among Kentucky MCO adults with multiple chronic conditions prior to a treat-and-release ED visit, the focus study identified the top 20 principal (first-listed) ICD-10 diagnoses for the first treat-and-release ED visit and the top 10 clinically meaningful categories, as defined by the Agency for Healthcare Research and Quality (AHRQ) for the first treat-and-release ED visit. Using the Clinical Classifications Software Refined (CCSR), the AHRQ groups ICD-10 diagnoses into clinically meaningful categories (CMCs) that more closely align with MCO population health categories. CMCs may or may not overlap with the FMC high-risk conditions, as well as the other clinical characteristics measured in this study, and were used to group the multiple specific ICD-10 diagnosis codes into larger categories, intended to simplify and enhance interpretation of clinical characteristics. 6. **Objective #2d** - Among Kentucky MCO adults with multiple chronic conditions prior to a treat-and-release ED visit, the focus study identified the top 20 ED hospitals for the first treat-and-release visit. 7. **Objective #3** - Among Kentucky MCO enrollees with multiple chronic conditions prior to a treat-and-release ED visit (Outcome 2), IPRO selected a random sample of 30 enrollees (+5 oversample) from each of the six MCOs, for a total targeted chart review sample size of 180. If an enrollee had multiple ED visits, the first ED visit during the MY was selected for the chart review. MCO care management charts were reviewed for MCO enrollees with a treat-and-release ED visit among adults with multiple chronic conditions prior to the first ED visit that meets the FMC criteria. Trained reviewers assessed enrollee receipt of the following: MCO care coordination to schedule a 7-day follow-up appointment and assessment and interventions to address barriers to attendance; an HRA; an enrollee needs assessment and specialist referrals; and a POC with goals and interventions to address the enrollee's multiple chronic conditions.
Disparities in Postpartum Care[2]	2025	The objective of the Disparities in Postpartum Care study was to evaluate associations between enrollee characteristics and the adverse outcomes of pregnancy-associated deaths and Severe Maternal Morbidity (SMM), as well as utilization of postpartum visits and postpartum ED encounters. The study incorporated a focus on evaluating disparities among Black/African American women relative to White women.
Disparities in Prior Authorization Denials and Appeals Among Kentucky Medicaid Managed Care Enrollees[3]	2024	The objective of the PA Denials and Appeals study was to identify disparities by the following utilization management (UM) outcomes among the eligible population of Kentucky MCO enrollees with a PA request during the period from July 1, 2022–June 30, 2023. Full denials and partial approvals were counted together as denials, consistent with the methodology used in a national study conducted by the United States Office of Inspector General (OIG): • **Outcome 1:** PA medical necessity denials appealed and upheld. • **Outcome 2**: PA medical necessity denials not appealed

Focus Study	Date Completed	Objectives
Disparities in Breast Cancer Screening (BCS)[4]	2024	The objective of the Disparities in BCS study was to identify demographic, clinical, SDoH, and healthcare system-related disparities among Kentucky MCO enrollees for receipt of BCS among women aged 40-74 years, quantify risk factors for non-receipt of mammography, and identify overrepresented subpopulations regarding breast cancer prevalence.
Access to Pediatric Oral Health Care Services[5]	2023	The objective of the Access to Pediatric Oral Health Care Services study was to assess the disparities in oral health services receipt and risk factors for non-receipt of oral evaluations, sealant, and topical fluoride application among children. MCOs utilized claims data to quantify receipt of and risk factors for non-receipt of oral healthcare services using multiple logistic regression analysis.
Prevalence and Risk Factors for Cesarean Delivery[5]	2023	The objective of the Prevalence and Risk Factors for Cesarean Delivery study was to quantify Cesarean delivery prevalence and risk factors using multiple logistic regression. The eligible population is specified as Kentucky MCO enrollees with a live or stillborn delivery during calendar year 2021. 1. The first objective was to use Kentucky MCO encounter/claims data to quantify Cesarean delivery prevalence and risk factors using multiple logistic regression. The associations between possible risk factors and the outcomes of total and low-risk Cesarean delivery were evaluated. 2. The second objective was to conduct a chart document review to assess whether there were medical indications or justifications for primary Cesarean delivery not identified by International Classification of Diseases, Tenth Revision (ICD10) codes, as well as to identify nonmedical reasons for primary Cesarean delivery. 3. The third objective was to analyze hospital practices for primary Cesarean deliveries by highest volume hospitals.

6.4 Annual EQR Technical Reports

Kentucky requires the contracted EQRO to perform the mandatory and optional EQR activities utilizing the nine protocol documents. Annually, the EQRO will review MCO compliance with state and federal regulations and state contract requirements and prepare a final, detailed technical report inclusive of all EQR and EQR-related activities. Annual technical reports can be searched on the DMS website at Reports - Cabinet for Health and Family Services including the most recent report at EQR Annual Technical Report State Fiscal Year 2025.

The EQRO provides monitoring of contracted MCOs. Specifically, the EQRO conducts on-site MCO annual compliance reviews, access and availability, validation of performance measures, validation of PIPs, and NCQA HEDIS compliance audits. An annual Technical Report is submitted to DMS, outlining review focus and findings as well as recommendations to each MCO on opportunities to improve DMS enrollee healthcare quality for the coming year.

The EQR technical report provides detailed information regarding the regulatory compliance of MCOs as well as results of PIPs, Performance Measures (PMs), and optional quality-focused activities. Report results provide information regarding the effectiveness of the MCOs program, identify strengths, and weaknesses and provide information about problems or opportunities for improvement. This information is incorporated into the Quality Strategy and used to initiate and develop QI projects.

Kentucky Medicaid uses the non-duplicative option for the Annual EQR Compliance activity. Our EQRO, IPRO, utilizes the MCO's NCQA Accreditation results in order to not duplicate efforts as part of the annual compliance review. The NCQA reports are cross walked to the Kentucky MCO contracts to identify those contractual requirements that can be deemed as compliant.

6.5 State Directed Payments

The May 2016 Managed Care Final Rule allowed Kentucky to make directed payments, which could either take the form of uniform payment increases or VBP for a class of providers. They allow Kentucky to make enhanced payments to providers to advance the goals of the Medicaid program. In general, directed payments are:

1. Based on the utilization and delivery of services.
2. Designed to advance at least one goal of the State Medicaid program's quality strategy with appropriate oversight to evaluate progress on the goals.
3. Evaluated at the end of each program year to measure progress on achieving outlined goals.
4. Submitted to CMS for approval annually.

DMS provides directed payments, as approved by CMS, to support provider payment initiatives which support both delivery reform and the Quality Strategy. The directed payments consist of a combination of uniform payment increases and VBP. These directed payments support three programs, a hospital rate improvement program, an ambulance provider assessment program, and university programs. These programs are evaluated annually and require annual CMS approval.

The hospital rate improvement program increases the funding available to hospitals to increase payments to advance the quality of care for Medicaid members. The value-based funding portion of the program consists of 10% of the pool. The Quality Strategy goals addressed are improved access to care, lower hospital readmissions, and two opioid related metrics.

The ambulance provider assistance program provides enhanced payments to ground ambulance service providers. The program addresses the quality goals of increasing access to care, increasing the

number of qualified ambulance providers, and reducing unnecessary spending. Associated quality goals are reducing ambulance response times and increasing the number of certified EMS practitioners.

Supplemental payments for university programs include increased operating expenses for pediatric teaching hospitals, a state-designated urban trauma center, state university teaching hospital faculty (medicine and dentistry), and a designated psychiatric hospital. These allowances preserve the ability of these entities to provide essential services to Kentucky residents.

Additional state-directed payments associated with the updated Quality Strategy will be considered as appropriate in consultation with partners and advisory groups.

Supplemental payments will be made in accordance with 42 C.F.R. 438.6(d).

The MCO shall make monthly supplemental payments to the specified providers on or before the last Business Day of the month of service for which Capitation is paid. Six (6) months following the end of this Contract, the Department or its designee will reconcile the supplemental payments between the Department and the MCO based on Total Enrollee Months during the Contract period.

6.6 Long Term Services and Supports (LTSS) Performance

Under Kentucky Revised Statute § 907 KAR 17:020, LTSS are not contracted for under managed care plans. They are managed by Fee for Service (Traditional) Medicaid.

6.7 Contract Violations, Breach, or Non-performance

The MCO shall comply with all terms, conditions, requirements, performance standards, and applicable Commonwealth and federal laws necessary in the performance of the MCO Contract or any amendments thereto, including any rules, policies, or procedures incorporated pursuant to this Contract.

DMS reserves the right to impose any remedies available under the terms of the Contract, at law, or equity if the Department determines, in its sole discretion, that the MCO or a MCO Subcontractor has violated any provision of the Contract, or if the MCO or a MCO Subcontractor does not comply with any other applicable Kentucky or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract.

6.7.1 Risk Categories

The MCO shall comply with all terms, conditions, requirements, performance standards, and applicable Commonwealth and federal laws necessary in the performance of the MCO Contract or any amendments thereto, including any rules, policies, or procedures incorporated pursuant to this Contract.

DMS reserves the right to impose any remedies available under the terms of the Contract, at law, or equity if the Department determines, in its sole discretion, that the MCO or a MCO Subcontractor of the MCO has violated any provision of the Contract, or if the MCO or a MCO Subcontractor does not comply with any other applicable Kentucky or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract.

DMS may conduct performance reviews at its discretion at any time that relate to any MCO responsibility for timely and responsive performance of Contract requirements. Based on such performance reviews or as determined through other means, upon the discovery of an MCO's or MCO Subcontractor's violation, breach, or non-performance of the terms, conditions, or requirements of the MCO Contract, DMS shall assign the violation, breach, or non-performance into one of the following

categories of risk: Category 1: Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Enrollee(s); reduces Enrollee's access to care; and/or jeopardize the integrity or viability of Kentucky's MCO program. Category 2: Action(s) or inaction(s) that jeopardize the viability or integrity of Kentucky's MCO program but does not necessarily jeopardize Enrollee'(s) health, safety, and welfare or reduce access to care. Category 3: Action(s) or inaction(s) that diminish(es) the efficient operation and effective oversight and administration of the Kentucky MCO program.

6.7.2 Requirement of Corrective Action

DMS will consider some or all the following factors in determining need to impose remedial action(s), intermediate sanction(s), penalty(ies), and/or liquidated damages against the MCO:

1. Risk category assignment based on the nature, severity, and duration of the violation, breach, or non-performance.
2. The type of harm suffered (e.g., impact to quality of care, access to care, Program Integrity).
3. Whether the violation (or one that is substantially similar) has previously occurred.
4. The timeliness in which the MCO self-reports a violation.
5. The MCO's history of compliance.
6. The good faith exercised by the MCO in attempting to stay in compliance (including self-reporting by the MCO).
7. Any other factor DMS deems relevant based on the nature of the violation, breach, or non-performance.

DMS may impose additional remedial actions, intermediate sanctions, penalties, or liquidated damages and/or elevate the violation to a higher Category of Risk if the noncompliance continues, or if the MCO fails to comply with the originally imposed action.

6.7.3 Letter of Concern

Should the Department determine that the MCO or any MCO Subcontractor is in violation or is at risk of violation of any requirement of this Contract, the Department shall issue a "Letter of Concern." The MCO shall contact the Department's designated representative within seven (7) Days of receipt of the Letter of Concern, or within an earlier timeframe if specified by the Department based on the nature, severity, and duration of the concern, and shall indicate how such concern is unfounded or how it will be addressed. If the MCO fails to timely contact the designated representative regarding a Letter of Concern, the Department shall proceed to the additional enforcement contained in this Contract.

6.7.4 Corrective Action Plan (CAP)

Should the Finance and Administration Cabinet or DMS determine that the MCO or any MCO Subcontractor is not in substantial compliance with any material provision of this Contract, FAC or the Department shall issue a Written Deficiency Notice to the MCO specifying the deficiency and requesting a CAP be filed by the MCO within ten (10) Business Days following the date of the notice. The Department reserves the right to require a more accelerated timeframe if the deficiency warrants a more immediate response.

A CAP shall delineate the following information at a minimum:

1. The names of the individuals who are responsible for implementing the CAP.
2. A description of the deficiency(ies) and the cause of the deficiency(ies) that resulted in need for corrective action.
3. A detailed approach for addressing the existing deficiency(ies) and prevention of the repeated and/or similar deficiency(ies) in the future.

4. The timeline for implementation, establishment of major milestones and correspondence dates to DMS, and notification of completion of corrective actions.

The CAP shall be subject to approval by FAC or the Department, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan within ten (10) Business Days of receipt. FAC or the Department may reduce the time allowed for corrective action depending on the nature of the deficiency.

6.7.5 Notice of MCO Breach

A MCO shall be considered in breach if the MCO is not in substantial compliance with any material provision of the MCO Contract that cannot be cured, if the MCO fails to cure a default in accordance with a plan of correction under Section 39.3 "Requirement of Corrective Action" after issuance of a Sanction, or comply with Sections 1932, 1903(m), and 1905(t) of the Social Security Act, or 42 C.F.R. 438. Upon determination of MCO breach, FAC shall issue a timely written notice to the MCO, explaining any Appeal rights provided to the MCO, indicating the nature of the default, and advising the MCO that failure to cure the default within a defined time period to the satisfaction of DMS, may lead to the imposition of any sanction or combination of sanctions provided by the terms of the MCO Contract, or otherwise provided by law, including but not limited to all of the following:

A. Suspension of receipt of further Enrollment for a defined time period after the date the Secretary or the Commonwealth notifies the MCO of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act.
B. Suspension of Capitation Payments for Enrollees after the effective date of the sanction and until CMS or DMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
C. Suspension or recoupment of the Capitation Rate paid for any month for any Enrollee who was denied the full extent of Covered Services meeting the standards set by the MCO Contract, or who received or is receiving substandard services.
D. A claim against MCO's Performance Bond.
E. Appoint temporary management.
F. Grant Enrollees the right to disenroll without cause and notifying the affected Enrollees of their right to disenroll.
G. Termination of the contract.

DMS shall impose mandatory temporary management when an MCO repeatedly fails to meet substantive requirements established in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. 438. It shall not delay the imposition of temporary management to provide a hearing and shall not terminate temporary management until it determines that the MCO can ensure the sanctioned behavior will not reoccur. If DMS imposes temporary management, DMS shall notify affected Enrollees of their right to terminate enrollment without cause, pursuant to 42 C.F.R. 438.706(b).

Additionally, DMS may impose civil money penalties in the circumstances and amounts as required in 42 C.F.R. 438.700.

7.0 PERFORMANCE MEASURES

7.1 Quality Measurement and Reporting

The MCOs incorporate outcomes measurement against relevant targets and benchmarks. DMS specifies performance and outcomes measures that MCOs must address, including HEDIS and Kentucky-specific measures. Note section 7.2 for additional detail on MCO claims-based quality reporting.

In addition to the analysis of claims data, DMS, MCOs, providers and other partners will work collaboratively to develop the capacity to use clinical quality data for value-based performance improvement. Clinical quality measures will be aligned with DMS Managed Care Quality Aims. DMS and MCOs will work with selected health care providers to monitor and report quality measures for Medicaid enrollees. DMS will establish state-level baselines for all reported measures and set performance thresholds for each measure using baseline data. To support the transition to VBC, providers need to meet or exceed the DMS performance thresholds for selected quality measures to be eligible for performance bonuses if applicable. The DMS will provide the MCO's with at least ninety (90) Days' notice, when possible, to make administrative changes to comply with any new measurement requirement.

7.2 Quality Strategy Development, Review, and Revision

The EQRO reviews the Quality Strategy annually. DMS contracts with Island Peer Review Organization (IPRO) as its EQRO. All contracts entered by DMS incorporate the requirements and language imposed under 42 CFR 438.

Additional input is incorporated from other state agencies, providers, consumers, and advocates who assist in identifying quality activities and metrics of importance to the Medicaid population. Results of annual reviews of the effectiveness of the prior year's quality plan and the EQR technical reports provide data to further focus strategy development.

MCOs conduct an annual survey of enrollees' and providers' satisfaction with the quality of services provided and their degree of access to services. The enrollee satisfaction survey requirement is satisfied by the MCO participating in the Agency for Health Research and Quality's (AHRQ) current CAHPS survey for Medicaid Adults and Children, administered by an NCQA certified survey vendor. Annually, the MCO is required to assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services. Additional sources of participant input include enrollee grievances, public forums. The MCOs provide a copy of the current CAHPS survey tool to the DMS.

Quality Strategy documents are posted on the DMS website for public comment. Each MCO establishes and maintains an ongoing Quality and Member Access Committee (QMAC) composed of enrollees, individuals from consumer advocacy groups or the community who represent the interests of the enrollee population and public health representatives. The DMS will annually seek and utilize input from the MCO's QMAC; the Medicaid Advisory Council established under 42 CFR 431.12; and the Medicaid TACs with consumer representation. This enrollee and partner input and public comment will be utilized as appropriate in the DMS's annual review and update of this QI strategy document and the state's quality initiatives.

7.3 Development and Implementation of the QI Plan

MCOs use UM/QI data to profile provider practices, comparing them against experience and norms for comparable individuals. UM/QI data are also used to profile the utilization of providers and enrollees and compare them against experience and norms. The EQRO conducts an annual provider data validation survey. The purpose is to determine the accuracy of the provider data files and determine whether the providers are available and accessible to DMS enrollees. Credentialing and re-credentialing is performed in compliance with NCQA standards, KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law.

The MCOs monitor provider actions to ensure they comply with the DMS policies which include:

- Maintaining continuity of the enrollee's health care
- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the MCO's network
- Maintaining a current medical record for the Enrollee, including documentation of all PCP and specialty care services
- Discussing Advance Medical Directives with all Enrollees as appropriate
- Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years
- Documenting all care rendered in a complete and accurate medical record that meets or exceeds DMS's specifications
- Arranging and referring enrollees when clinically appropriate, to behavioral health providers.

Providers will be terminated from participation if they: (i) engage in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) have a license, certification, or accreditation terminated, revoked or suspended; (iii) have medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engage in behavior that is a danger to the health, safety or welfare of enrollees. The MCO is to notify the DMS if this occurs. Likewise, the DMS will notify the MCO of any suspension, termination, and exclusion actions taken against Medicaid providers by the DMS.

The MCO, through the QAPI program, shall monitor and evaluate progress in improving the quality of health care and outcomes on an ongoing basis and provide updates to DMS on progress during quality meetings and at DMS's request on an ad hoc basis. Health care needs such as preventive care, acute or chronic physical or behavioral conditions, SDoH and high volume, high risk, and special health care needs populations shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines.

As stated in MCO contracts, the MCO shall develop or adopt Clinical Practice Guidelines (CPG) that are disseminated to Providers, and, upon request, to Enrollees and Potential Enrollees. The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals; consider the needs of Enrollees; developed or adopted in consultation with contracting health professionals and reviewed and updated periodically.

IPRO performs an Annual Compliance Review where each MCO is required to present evidence that they have met the Federal and State requirements for Practice Guidelines.

The MCO's Quality Management and performance improvement activities shall demonstrate the linkage of quality initiatives and projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified through performance metrics (e.g., annual HEDIS™

indicators), results of consumer and provider surveys, internal surveillance, and monitoring, as well as any findings identified by DMS or an accreditation body.

The MCO shall use appropriate multidisciplinary teams to analyze and address data or systems issues. The MCO shall collaborate with existing provider QI activities and, to the extent possible, align with those activities to reduce duplication and to maximize outcomes.

Providers shall be measured against practice guidelines and standards adopted by the QI Committee. Areas identified for improvement shall be tracked and corrective actions taken as indicated. The effectiveness of corrective actions shall be monitored until problem resolution occurs. The MCO shall perform reevaluations to ensure that improvement is sustained.

The MCO shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Enrollees. The MCO shall modify as necessary, the QAPI program, including QI policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Enrollees. The MCO shall prepare a written report to DMS detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Enrollees. The MCO shall submit this report as specified by DMS. DMS shall give the MCO advance notice of the due date of the annual QAPI report. DMS may require interim reports more frequently than annually to demonstrate MCO progress.

7.4 Role of Utilization Management (UM)

The MCO's UM program and processes are to be in accordance with 42 CFR 456, 42 CFR 431, 42 CFR 438 applicable state and federal laws and regulations, and NCQA standards. Timeframes for service review decisions will conform to those set forth in 42 CFR 456. The program identifies and describes the mechanisms to detect under-utilization as well as over-utilization of services.

The MCO's QI Plan contains methods for integrating the QI activity with other management activities including UM. The MCOs analyze and report on trends in utilization, and any unusual patterns about which the MCO will take subsequent action. The utilization of management/quality improvement (UM/QI) data is used to produce reports which focus on access, availability and continuity of services, quality of care, detection of over and underutilization of services, and the development of defined reporting criteria and standards.

The MCOs UM program also monitors and evaluates the appropriateness of care and services on an ongoing basis. Each MCO is required to establish an internal UM committee, including Kentucky-based provider representation, that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization, patterns of care, and key utilization indicators.

The MCO develops or adopts written medical necessity review criteria that are based on sound medical evidence or judgment. These criteria are reviewed at least annually and updated as needed by the MCO. DMS reviews and approves the criteria prior to use and requires adequate notification to the providers of any change in criteria. The MCO includes practicing physicians and other providers in the MCO's provider network in the review and adoption of medical necessity criteria. The MCO has in place mechanisms to check the consistency of the application of review criteria.

The UM Program and Review Plan include written policies and procedures for complying with the Mental Health Parity and Addiction Equity Act (MHPAEA)

7.5 Quality and Performance Modeling of Individual Providers

MCOs use UM/QI data to profile provider practices, comparing them against experience and norms for comparable individuals. UM/QI data are also used to profile the utilization of providers and enrollees and compare them against experiences and norms. The EQRO conducts an annual provider data validation survey. The purpose is to determine the accuracy of the provider data files and determine whether the providers are available and accessible to DMS enrollees. Credentialing and re-credentialing is performed in compliance with NCQA standards, and applicable state regulations and federal law.

The MCOs monitor provider actions to ensure they comply with the DMS policies that include:

- Maintaining continuity of the enrollee's health care;
- Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the MCO's network;
- Maintaining a current medical record for the Enrollee, including documentation of all PCP and specialty care services;
- Discussing Advance Medical Directives with all Enrollees as appropriate;
- Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;
- Documenting all care rendered in a complete and accurate medical record that meets or exceeds DMS's specifications; and
- Arranging and referring enrollees when clinically appropriate, to behavioral health providers.

Providers will be terminated from participation if they: (i) engage in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) have a license, certification, or accreditation terminated, revoked or suspended; (iii) have medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engage in behavior that is a danger to the health, safety or welfare of enrollees. The MCO is to notify the DMS if this occurs. Likewise, the DMS will notify the MCO of any suspension, termination, and exclusion actions taken against Medicaid providers by the DMS.

When a Provider elects to terminate its contract with the MCO, the MCO shall notify the Department via SharePoint of such a Provider termination, with or without cause, within three (3) Business Days of the contract termination date. The MCO shall survey all Providers who choose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment.

7.6 Frequency of State Reviews and Effectiveness of the Quality Strategy

DMS or its contracted agent will have the right to conduct periodic audits of the MCOs during which DMS will identify and collect management and quality data on the use of services or other information as determined by the DMS. Among other items, these assessments include evaluation of the MCO's QI Program description, QI plan and the MCO's annual evaluation description, policy and procedures, and implementation of the procedures. The contracted EQRO will perform an annual review of MCOs compliance with state and federal regulations. This activity includes documentation review and interviews with MCO staff.

DMS performs an assessment and analysis of both the MCOs' quarterly and annual reports along with the results from the implementation of this quality plan. This assessment will evaluate the overall

quality of service provided and planned improvements by the MCOs. Minor discrepancies are brought to the attention of the MCO through regularly scheduled meetings and in writing for more serious issue or concern. Identified significant deficiencies will result in request(s) for CAP(s) from the MCO as described within the MCO contract.

7.7 Significant Changes to the Quality Strategy

Significant changes to the quality strategy include any written change to policy or procedure that results in a required change to the QI program and plan, which will trigger partner input regarding its implementation. Examples might include changes in federal or state laws and regulations, results of annual reports from the MCOs including consumer surveys, excessive complaints, grievances and appeals, or results from oversight activity performed by the Commonwealth or the EQRO. Avenues for partner input include submitted complaints (in writing and through telephone calls), written surveys, questionnaires posted on the DMS website, and in extreme cases direct communication by the DMS. The Commonwealth will submit a revised Managed Care (MC) QI Strategy to CMS when significant changes are made.

8.0 MCO STANDARDS

8.1 State-Defined Network Adequacy and Availability of Services

The MCO shall meet the Provider Network access and adequacy standards consistent with KRS 304.17A-515 and established by DMS as described in this section unless otherwise approved by the DMS in accordance with the requirements set forth in the MCO Contract. Any exceptions shall be justified and documented by the MCO in accordance with "Exceptions to Provider Network." Significant changes in the MCO's Network composition that reduce Enrollee access to services may be grounds for Contract termination.

DMS may amend these standards as deemed appropriate throughout the Contract Term. The MCO shall comply with modified standards as directed, but with no less than a ninety (90) Day prior notice unless another timing is required by federal or state regulation.

The MCO shall make available and accessible facilities, Service Locations, and personnel sufficient to provide Covered Services consistent with the requirements specified in this subsection.

Consistent with KRS 304.17A-515, the MCO shall have a Provider Network that meets the following accessibility requirements:

A. For urban areas, a Provider Network that is available to all Enrollees within thirty (30) Miles or thirty (30) minutes of each Enrollee's place of residence or work, to the extent that services are available;

   For areas other than urban areas, a Provider Network that makes available PCP and hospital services within thirty (30) minutes or thirty (30) Miles of each Enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all Enrollees within fifty (50) minutes or fifty (50) Miles of each Enrollee's place of residence or work, to the extent those services are available.

In addition, the MCO shall meet the following as required by DMS:

B. Enrollee to PCPs ratios shall not exceed 1500:1 Full-Time Equivalent (FTE) Provider for children under twenty-one (21) and adults;

C. Specific to voluntary family planning, counseling and medical services as soon as possible within a maximum of thirty (30) Days. If not possible to provide complete medical services to Enrollees less than eighteen (18) years of age on short notice, counseling and a medical appointment as immediately as possible and within ten (10) Days;
D. Appointment and wait times shall not exceed thirty (30) Days from date of an Enrollee's request for routine and preventive services and forty-eight (48) hours for Urgent Care:
    1. PCPs for both adults and pediatrics
    2. Specialists designated by DMS including sufficient adult specialists to meet the needs of Enrollees twenty-one (21) years of age and older and pediatric specialists to meet the needs of Enrollees under age twenty-one (21)
    3. General and pediatric dental services
    4. General vision services
    5. Laboratory and radiology services.
E. If either the MCO or a Provider (including Behavioral Health) requires a referral before making an appointment for Specialty Care, any such appointment shall be made within thirty (30) Days for routine care or forty-eight (48) hours for Urgent Care
    1. Emergency Medical and Behavioral Health Services shall be made available and accessible to Enrollees twenty-four (24) hours a day, seven (7) Days a week. Urgent care services by any provider in the MCO's Network shall be made available and accessible within forty-eight (48) hours of request; and
    2. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness, or condition, regardless of whether the facility is in the MCO's Network.

       The MCO shall monitor the usage of Emergency Rooms in each Medicaid Region by Enrollees for non-emergent visits and provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Enrollees to reduce unnecessary Emergency Room visits.

       The MCO shall develop and provide GeoAccess reports to DMS in accordance with the "Reporting Requirements and Reporting Deliverables" and as directed by DMS. The MCO shall utilize the most recent GeoAccess program versions available and update them periodically and on a timeline defined by DMS. The MCO shall use GeoCoder software along with the GeoAccess application package.

       The MCO shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for 16 or more hours in an office location each week. For Providers who have more than one (1) office, the MCO must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is one hundred fifty (150), and the Provider has two (2) offices, each office would have a capacity of seventy-five (75). The individual capacity option should be used when reporting PCPS.

       A ninety percent (90%) appointment wait time standard shall be achieved to ensure compliance with the above standards; and The MCO shall monitor appointment wait time compliance through Secret Shopper surveys.

       Secret Shopper surveys are also conducted by DMS' EQRO, on an annual basis as mandated by CMS. The EQRO will evaluate directory accuracy, network participation, and compliance with appointment wait time standards. The calls will evaluate statistical

samples of primary care, OB/GYN, and behavioral health providers. The survey results will be reported to CMS and published on the DMS website.

8.2 Enrollment and Disenrollment

DMS has the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become an Enrollee of the MCO. Such determination shall be final and is not subject to review or Appeal by MCOs. To be eligible for MCO enrollment, an individual must be qualified to receive medical assistance under one of the Medicaid assistance categories and be a resident of the MCO service area. MCOs provide for a continuous open enrollment period throughout the term of the Contract for newly eligible Enrollees. MCOs cannot discriminate against potential Enrollees on the basis of an individual's health status, need for health services, race, color, religion, gender, sexual orientation, gender identity, disability or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of an Enrollee's health status, need for health services, race, color, religion, gender, sexual orientation, gender identity, disability or national origin. Enrollment begins at 12:01 a.m. on the first day of the first calendar month for which eligibility is indicated on the eligibility file (Health Insurance Portability and Accountability Act of 1996 (HIPPA) 834)) transmitted to the MCO and shall remain until the Enrollee is disenrolled in accordance with Disenrollment provisions of the MCO Contract. Applicable state and federal law determine membership for newborns. Membership begins on the day of application for Enrollees who are presumptive eligible. An Enrollee may request Disenrollment only with cause pursuant to 42 C.F.R. 438.56. MCOs will follow the Disenrollment for Cause process as defined by DMS. Only DMS may disenroll an enrollee from the plan.

The MCO shall also be responsible for providing coverage to individuals who are retroactively determined eligible for Medicaid. Retroactive Medicaid coverage is defined as a period of time up to three (3) months prior to the application month. The MCO shall cover all Medically Necessary services provided to the Enrollee during the retroactive coverage without a PA.

8.3 Availability of Services

MCOs maintain and monitor a network of appropriate providers (including hospitals, home health providers, dentists, vision providers, hospice, pharmacy, prevention, primary care, and at least one provider of maternity care), representing the complete array of provider types including primary care providers, primary care centers, federally qualified health centers, and rural health clinics, local health departments and the Kentucky Commission for Children with Special Health Care Needs, among other requirements. MCOs also comply with the following service availability requirements:

- All covered services are as accessible to enrollees as generally available to commercial insurance enrollees, and there is no incentive for providers to withhold medically necessary services;
- If the MCO is unable to provide necessary medical services covered under the contract, it will timely and adequately cover these services out of network, coordinating appropriate payment and ensuring that the cost to the enrollee is no greater than it would be if provided in-network;
- Direct access of female enrollees to qualified women's health specialists is ensured within the network;
- Second opinions related to surgical procedures and the diagnosis and treatment of complex and/or chronic conditions will be provided within or outside the network;
- Providers may advise the beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under Medicaid; and

- MCOs promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

8.4 Assurances of Adequate Capacity and Services

MCOs offer an appropriate range of medically necessary preventive, primary care, specialty, and emergency services as required by federal and state regulations, guidelines, transmittals, and procedures. Medically necessary services are those considered by the DMS to be reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative, or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(r). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

8.5 Provider Selection

MCOs have written policies and procedures regarding the selection and retention of their provider network. These procedures must not discriminate against providers who service high- risk populations or who specialize in conditions that require costly treatment or based upon a provider's licensure or certification. They must also comply with the Any Willing Provider provisions set forth in 907 KAR 1:672 and KRS 304.17A-270. MCO provider networks must offer sufficient types, numbers, and specialties in each county to assure quality and access to health care services.

All MCO network providers, including individuals and facilities, who will provide health care services must have a valid license or, where required, certified to provide health care services in the Commonwealth, including certification under Clinical Laboratory Improvement Amendments (CLIA), if applicable. They must also have a valid Drug Enforcement Agency (DEA) registration number, if applicable. The following providers must be accountable to a formal governing body for review of credentials: physicians, dentists, advanced registered nurse practitioners, vision care and other licensed or certified practitioners. MCOs will be responsible for the ongoing review of provider performance and credentialing.

8.6 Subcontracts and Delegation

The MCO may, with the approval of DMS, enter into Subcontracts for the provision of various Covered Services to Enrollees or other services that involve risk-sharing, medical management, or otherwise interacting with an Enrollee or Provider, except the MCO shall not enter into any Subcontract with MCO Subcontractors outside of or that would be providing any services outside the United States. All MCO Subcontractors shall have and maintain Kentucky specific expertise in each content area for which they are providing services.

MCO subcontractors must be eligible for participation in the Medicaid program, pursuant to federal and state regulations. The MCO shall evaluate each prospective MCO Subcontractor’s ability to perform the proposed delegated activities. The MCO shall execute a written contractual agreement (Subcontract) between the MCO and MCO Subcontractor that is in a form and has content approved by DMS. Furthermore, the MCO shall submit any change in terms or scope of a Subcontract, notice of suspension or termination of a Subcontract to DMS for review and approval. The MCO shall submit for review to DMS a listing of MCO Subcontractors who will support their Contract, a description and role of each MCO Subcontractor, detail listing of services provided, all locations of operation including disclosure of any and all operations outside the United States, and a template agreement of each type of such Subcontract referenced herein.

DMS may approve, approve with modification, or reject the templates if they do not satisfy the requirements of the MCO Contract. In determining whether DMS will impose conditions or limitations on its approval of a Subcontract, DMS may consider such factors as it deems appropriate to protect the Commonwealth and Enrollees, including but not limited to, the proposed MCO Subcontractor's past performance. In the event DMS has not approved a Subcontract referenced herein prior to its scheduled effective date, the MCO agrees to execute said Subcontract contingent upon receiving DMS's approval. No Subcontract shall in any way relieve the MCO of any responsibility for the performance of its duties pursuant to the MCO Contract including the processing of Claims. Likewise, any DMS Subcontract approval does not in any way relieve the MCO of any responsibility or liability for the performance of its duties pursuant to the MCO Contract. The MCO shall submit a summary of the services for which the MCO Subcontractor is responsible for the Subcontract.

8.7 Practice Guidelines

MCOs maintain an overall Quality Improvement Plan (QIP) with practice guidelines or standards against which clinical care is compared, based on the most recent published evidence. MCOs are encouraged to use state and national practice guidelines and assess suitability with appropriate health care professionals. Prior to implementation and upon renewal, each practice guideline is reviewed for consistency with UM criteria, medical education, available benefits and disease management programs materials. Specific guidelines are adopted for treatment of enrollees with special health care needs and complex, chronic conditions. Practice guidelines are disseminated to the MCO's Network, and to enrollees, and potential enrollees upon request.

MCOs annually review, evaluate and modify as necessary their QIPs, including clinical care standards, practice guidelines, and patient protocols. Each year, they prepare an annual report to the DMS, detailing their review, completed activities, corrective actions (including recommended and in progress), and results of all clinical, administrative, provider and enrollee satisfaction surveys conducted during the immediately preceding year.

8.8 Coordination and Continuity of Care

8.8.1 Primary Care Provider (PCP)

MCOs ensure that each enrollee has an ongoing source of primary care through a PCP. PCP means a licensed or certified health care practitioner, including a Doctor of Medicine, doctor of osteopathy, advanced registered nurse practitioner, including a nurse practitioner, nurse midwife and clinical specialist, physician assistant, or clinic, including a primary care center and rural health clinic, that functions within the scope of licensure or certification, have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals. For an enrollee who has gynecological or obstetrical health care needs, disability, or chronic illness, the PCP can be a specialist who agrees to provide and arrange for all appropriate primary and preventive care. MCOs have procedures for serving enrollees from the enrollment date, regardless of whether they have selected a PCP.

MCOs are required to send enrollees a written explanation of the PCP selection process within five business days of enrollment to include: time frame for PCP selection, explanation of the PCP selection/assignment process, and where to call for assistance. MCOs are responsible for explaining and facilitating the selection of or change in PCP through telephone or face-to-face contact where appropriate. They assist enrollees in making the most appropriate PCP selection based on previous or

current PCP relationship, providers of other family enrollees, medical history, language needs, provider location or any other factors that are important to the enrollee.

The MCOs ensure that acceptable after-hours phone arrangements are implemented by PCPs in the MCOs Network including Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner.

8.8.2 Coordination of All Services that Enrollees Receive

MCOs establish referral relationships with various human service agencies whose services are outside the scope of covered services, but important to the health of enrollees. Case Management is provided by the MCO to enrollees, as appropriate, and specialized Case Management services are provided for enrollees with complex and/or chronic conditions. Through information sharing and monitoring, PCPs are responsible for coordinating assessment and treatment, and following enrollees as they use multiple providers, services sites, and levels of care.

8.8.3 Prevention of Duplication of Services for Individuals with Special Health Care Needs

The Department for Community Based Services (DCBS) and the Department for Aging and Independent Living (DAIL) will complete a service plan for all clients who receive services from DCBS and DAIL who are newly enrolled in an MCO. This service plan will be forwarded to the MCO before enrollment and will be used by DCBS, DAIL, and the MCO to determine enrollee medical needs and the potential need for specialized case management, coordinate care, and avoid duplication of services. The DCBS population includes Adult Guardianship Clients, Children in Foster Care, and Children Receiving Adoption Assistance. Dual Eligible Enrollees will be identified by the management information system.

MCOs also assure and facilitate direct access to specialty physicians for individuals who have been identified as having Special Healthcare Needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through standing referrals from the PCP or by the specialty physician being permitted to serve as the PCP.

8.9 State Transition of Care Policy

Upon receipt of an indication that a Member is transferring from one MCO to another MCO, the former MCO shall be responsible to contact the new MCO, the recipient and the recipient's providers in order to transition existing care. A PA shall be honored by the new MCO for 90 Days or until the recipient or provider is contacted by the new MCO regarding the PA. If the recipient and provider are not contacted by the new MCO, the existing Medicaid PA shall be honored until expired.
The Former MCO shall provide the following information to the New MCO:
1. Care coordination data, including data from assessments of Enrollees' health risks, care needs, or functional status; care plan information; and
2. Rosters of transitioning plan Enrollees whose health status or care needs may be especially complex, such as individuals who are pregnant, homeless, or individuals with certain disabilities.

- **Inpatient Hospital Admission Prior to the Member's Transition.**
  If the Member is an in-patient in an acute care hospital, critical care hospital, acute rehabilitation facility, psychiatric hospital or long-term acute care facility at the time of transition, the entity responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from the facility for the current admission. An inpatient admission

within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

- **Outpatient Facility Services and Non-Facility Services**
  Effective on the Member's Transition date, the new MCO will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospitals, ambulatory surgery centers, and renal dialysis centers.
- **Nursing Homes**
  Eligibility for Long Term Care in a Nursing Facility (NF) includes some financial requirements not needed for basic Medicaid eligibility. When an eligible member enters an NF the facility must receive a Level of Care (LOC) determination to ensure the member meets medical criteria for Nursing Facility. That LOC is passed electronically to the DCBS eligibility worker, triggering the eligibility determination for this additional benefit. That determination can generally be completed within thirty Days. Once LTC eligible, worker entries exempt the member from managed care effective with the next feasible month. If the worker action is completed prior to cut off (eight Business Days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for ancillary, physician and pharmaceuticals charges and the Department will reimburse for those services billed by Nursing Facility. Once exempt from Managed Care, DMS will be responsible for all eligible services associated with this recipient.
- **Waiver Participation**
  1915(c) Home and Community Based Services Waiver programs are simply added benefits for eligible members; however, the action that exempts those members from being subject to Managed Care resides with the DCBS eligibility worker. These services require a Level of Care (LOC). The LOC is passed electronically to the DCBS eligibility worker; receipt of the LOC triggers the eligibility worker to complete entries within the eligibility system. Those entries exempt the member from managed care effective the next feasible month. If the worker action is completed prior to cut off (eight Business Days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for all services except the additional Waiver benefits. The Waiver Services will be paid by DMS as fee for service. Coding in the billing system allows the Wavier Service to be processed during the transition period, once the eligibility worker has completed the necessary entries. Once exempt from Managed Care, DMS will be responsible for all services associated with this recipient.
- **Transplants**
  Follow up care provided on or after the Member's Transition that is billed outside the Global Charges, will be the responsibility of the new MCO.
- **Eligibility Issues**
  For a Member who loses eligibility during an inpatient stay, an MCO is responsible for the care through discharge if the hospital is compensated under a Design and development of the Diagnosis Related Group (DRG) methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology. If a member with no prior or other coverage becomes eligible during a hospital stay, MCO is responsible for the hospital stay on the day of eligibility.

8.10 Coverage and Authorization of Services

MCOs provide or arrange for the provision of covered services to all enrollees in accordance with DMS policies and procedures applicable to each category of covered services. MCO is also required to maintain a comprehensive UM program that reviews services for medical necessity and evaluates the appropriateness of care and services for physical and behavioral health. Written clinical criteria and protocols will include a mechanism for obtaining all necessary information, including pertinent clinical information, and a consultation with the attending physician or other health care provider as appropriate. The MCO Medical Director and Behavioral Health Director will supervise the UM program and will be accessible and available for consultation as needed. Decisions requiring clinical judgment and denials based on lack of medical necessity must be made by qualified medical professionals.

8.11 Identifying special Populations

Individuals needing LTSS are beneficiaries of all ages who have functional limitations or chronic illness and require services and supports whose primary purpose is to support the enrollee's ability to live or work in the setting of their choice. These settings may include enrollee home, worksite, provider-owned or controlled residential setting, nursing facility, or other institutional setting. Under Kentucky statutes, LTSS beneficiaries are covered under the fee-for-service program, not managed care.

ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional conditions and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their condition(s). The primary purpose of the definition is to identify these individuals so that MCOs can facilitate access to appropriate services. DMS has defined the following categories of individuals who shall be identified as ISHCN.

- Children in/or receiving Foster Care or adoption assistance;
- Blind/Disabled Children under age 19 and Related Populations eligible for SSI;
- Adults over the age of 65;
- Homeless (upon identification);
- Individuals with chronic physical health illnesses; and
- Individuals with chronic behavioral health illnesses.

To identify these special populations, MCOs will be responsible for the following:

- Have written policies and procedures in place, which govern how enrollees with these multiple and complex care needs are further identified.
- Request all enrollees complete an initial HRA within 90 days of enrollment. Information to be collected will include demographic, socioeconomic, current health status, and behavioral risk questions and be inclusive enough to determine the enrollee's need for care management, disease management, mental health services, and/or any other health services. The information collected will identify the health education needs of enrollees and provide the basis for the health education program
- Maintain internal operational processes to target enrollees for screening and identification.
- Assess each enrollee identified to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process uses appropriate health professionals.

8.12 Health Information Systems

MCOs maintain a Management Information System (MIS) that provides support for all aspects of a managed care operation and includes the following subsystems: enrollee, third party liability, provider, reference, encounter/claims processing, financial utilization data, QI and surveillance utilization review. The *enrollee subsystem* maintains an accurate record of demographic information for current and historical MCO enrollees. The *provider subsystem* includes demographic data, provider type, specialty codes, licensing, credentialing, and re-credentialing information, PCP enrollment capacity, and provider payment information. The *financial subsystem* tracks all financial transactions, including claim payments, adjustments and recoupments, and accounts receivable. This subsystem ensures that all funds are appropriately disbursed, and all post-payment transactions are applied accurately. As a final step, this system produces remittance advice statements/ explanations of benefits and financial reports. The *utilization/quality improvement subsystem* is used to profile providers, monitor primary care and specialty referral patterns, and examine the use of specific services (e.g., EPSDT, out-of-network), assess care treatment and medication use patterns across settings (comparing to established standards), and conduct adverse event reporting, including adverse incidents and complications. The *Surveillance Utilization Review Subsystem (SURS)* is used to identify potential fraud and/or abuse by providers or enrollees. SURS supports profiling, random sampling, groupers (for example Episode Treatment Grouper), ad hoc, and targeted queries.

Additional requirements include:

- MCOs must ensure that all medical information is kept confidential through appropriate security and privacy protocols.
- MCOs must ensure that data received from providers is accurate and complete by collecting service information in standardized formats whenever feasible and appropriate, verifying the accuracy and timeliness of reported data (through audits and edits consistent with National Correct Coding Initiative (NCCI)), screening data for completeness, logic and consistency, and storing all claims and encounter data in a data warehouse.
- MCOs must make all collected data available to the DMS and provide additional data and reports as requested by the DMS. At a minimum, MCOs must electronically provide encounter data to DMS monthly. Encounter data must follow the format, data elements, and method of transmission specified by the DMS. If the MCO knowingly fails to submit data derived from processed claims or encounter data as required by the terms of the contract or data from processed claims otherwise specified by the DMS under the contract, the DMS may assess penalties.
- Encounter data is used by DMS to 1) evaluate access to care, availability of services, quality of care; 2) evaluate contractual performance; 3) validate required reporting of utilization of services; 4) develop and evaluate proposed or existing capitation rates; 5) meet CMS Medicaid reporting requirements.
- The contracted EQRO will perform encounter data validation to determine the accuracy and adequacy of claims submitted by the MCO.
- MCOs, and their subcontractors, must make all of their books, documents, papers, provider records, medical records, data, surveys and computer databases available for examination and audit by the DMS, the Attorney General of the Commonwealth of Kentucky, the Office of Insurance of the Commonwealth of Kentucky, authorized federal or Commonwealth personnel, or the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, or agent of the DMS, Cabinet for Health Services, and CMS.

8.13 Confidentiality

MCOs have the responsibility to protect enrollee information from unauthorized disclosure for any reason. MCOs maintain confidentiality through written policies and procedures designed to protect the rights of enrollees including, but not limited to, the right to respect, dignity, privacy, confidentiality, and nondiscrimination. MCOs agree to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Confidentiality of all enrollee information is mandatory, and a breach of confidentiality is considered as a basis for immediate revocation of the MCO Contract. Policies and procedures shall include but not be limited to, adequate provisions for ensuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as in KRS 214.185.

8.14 Grievances and Appeals

Any enrollee has a right to file a grievance with the MCO or the DMS if they are dissatisfied with anything related to the MCO and may file an appeal related to actions or decisions made by the MCO related to covered services or services provided. MCOs maintain a timely and organized Grievance System for resolving oral and written grievances filed by enrollees. The MCOs Grievance Systems offer a grievance process, an appeal process, and access for enrollees to the State's fair hearing system.

Every grievance received will be documented in an MCO’s management information system. MCOs maintain written policies and procedures for the receipt, handling and disposition of grievances that comply with 42 CFR 438 Subpart F and 42 CFR 431. These policies and procedures include a process for evaluating patterns of grievances for impact on formulation of policy and procedures, access, and utilization. They also outline procedures for maintaining grievance records separate from medical case records to protect the confidentiality of enrollees who file a grievance or appeal.

MCOs submit quarterly reports of all enrollee grievances and appeals and their disposition to DMS and their QMAC. These reports include the number of grievances and appeals (including expedited appeal requests), nature of grievances and appeals, resolution, and timeframe for resolution. DMS or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated grievances or appeals. Any patterns of suspected fraud or abuse identified through the data will be immediately referred to the MCO’s Program Integrity Unit.

DMS staff review quarterly MCO reports and share with the EQRO, which reviews and annually reports on all services denied by the MCO or its subcontractors and related appeals. Minor discrepancies are brought to the attention of MCOs through regularly scheduled meetings and in writing, for more grievous errors. Significant deficiencies result in an MCO corrective action. The DMS shall provide a standardized form for MCO’s to utilize for an Enrollee to begin the MCO’s grievance and Appeal process

Grievance or Appeal files shall be retained for ten (10) years following the final decision by the MCO, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

9.0 QUALITY MEASUREMENT & IMPROVEMENT STANDARDS

The DMS, as well as the MCOs, are responsible for monitoring targeted quality and health outcomes measures, collaboratively developing annual benchmark goals. The DMS reserves the right to assess an MCO's achievement of goals, and if it is determined that goals have not been achieved, DMS will initiate a CAP to be performed by the MCO. MCOs implement steps targeted at either improving the actual outcomes or the underlying processes that affect those outcomes. Additionally, a mechanism to update standards and guidelines and disseminate revised information to practitioners is required.

The EQRO conducts an annual validation of these performance measures by evaluating the accuracy of the performance measures reported by the MCO and determining the extent that the Medicaid specific performance measures follow the specifications established by the DMS for the calculation of the performance measures. The EQRO also conducts an annual analysis of utilization patterns of services and delivery sites to determine shifts in access to care, e.g., under- utilization or inadequate access to healthcare providers. Finally, the EQRO annually reviews MCO compliance with state and federal standards and state MCO contract requirements. The EQRO produces a report that describes the manner by which data from all EQR and EQR related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness and access to care furnished by the MCOs.

Each MCO establishes and maintains an ongoing Quality Member Advisory Committee (QMAC) composed of enrollees, individuals from consumer advocacy groups, the community, who represents the interests of the enrollee population, and public health representatives.

Enrollees of the committee are consistent with the composition of the enrollee population, including such factors as aid category, gender, geographic distribution, parents, as well as adult enrollees, and representation of racial and ethnic minority groups. Responsibilities of the committee include (summarizing from among other required items): providing review and comment on the quality and access standards; providing review and comment on the grievance and appeals process as well as policy modifications needed based on a review of aggregate grievance and appeals data; review, and provide comments on Enrollee Handbooks; reviewing enrollee education materials prepared by the MCO; recommending community outreach activities, and providing reviews of and comments on MCO and DMS policies that affect enrollees.

9.1 Assessment of quality and appropriateness for enrollees with special needs

The MCO regularly reports data and other summary reports to assess the quality and appropriateness of care and services supplied under the MCO Contract to all enrollees, including those populations previously identified in this document as special populations.

Quarterly and annually, the MCO submits a report on quality assurance activities during the reporting period. A description of the activities such as current or proposed QIP, updates on these projects including any relevant attachments, results of medical record review(s), or chart abstraction activities for establishing baselines. Also included is a discussion of the MCO's use of encounter data in monitoring utilization and quality and identification of any problems regarding the completeness and accuracy of the data. The MCO will also report on activities during the reporting period associated with sub-populations and individuals with special healthcare needs.

9.2 Mandatory External Quality Review

DMS maintains a contract with an EQRO to perform external quality review functions. The EQRO performs the federally required reviews of access to care, quality of care, and the effect of care coordination. EQR is the analysis and evaluation by an EQRO of aggregated information on quality,

timeliness, and access to the health care services that an MCO or their subcontractors furnish to Medicaid enrollees. Requirements and procedures for EQR of Medicaid MCOs are established in the Code of Federal Regulations (42 CFR Parts 433 and 438) Final Rule. Three mandatory activities are conducted to provide information for EQR are identified in 42 CFR 438.358, which include the following:

- The review of compliance with structural and operational standards,
- The validation of performance measures,
- The validation of PIPs.

DMS may determine which optional activities are included in the EQR and what types of performance measures and PIPs require of their contracting MCO. The Final Rule also requires that aggregated information is obtained from activities that are consistent with protocols, as defined in the rule, to ensure that data to be analyzed are collected using sound methods widely used in the industry. The DMS has contracted with a single EQRO to perform the mandatory and optional EQR activities.

Quarterly Reports containing a summary of EQR activities for the quarter and are provided to DMS on a quarterly schedule. An Annual Report is provided containing a detailed technical report describing the manner by which the data from all EQR and EQR-related activities were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to care furnished by each MCO. The report will include an assessment of the MCO's strengths and weaknesses and recommendations for improvement for each of the activities conducted. This report is posted online at Reports - Cabinet for Health and Family Services.

9.3 Health Equity

The Commonwealth identifies of Medicaid MCO enrollees at the time of application for Medicaid at the DCBS local office.

The Kentucky Department for Public Health, Office of Health Equity (OHE) was established in September 2008 to address health disparities among minority and rural Appalachian populations. Grant support has been received from the U.S. Department of Health and Human Services, Office of Minority Health (OMH) since 2010. OHE supports goals and evidence-based strategies from the National Partnership for Action to End Health Disparities (NPA) to mobilize a statewide, comprehensive, community-driven, and sustained approach to combating health disparities and to move Kentucky toward achieving health equity. OHE also supports a wide variety of activities and services through partnerships with health departments, universities, nonprofit organizations, and private health systems. The Kentucky OHE has five focus areas and goals:

- Education and Awareness – Increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve the health outcomes for minority, rural, and low-income populations of Kentucky.
- Cultural Competency – Improve the health and health care outcomes for minority and underserved communities through evidence-based tailored approaches that account for differences in culture and language.
- Research – Improve the coordination and utilization of research to advance health equity for minority and underserved communities.
- Evaluation – Improve the coordination and utilization of evaluation outcomes to advance health equity for minority and underserved communities.
- Strengthening Partnerships – Strengthen and broaden leadership in Kentucky for addressing health disparities at all levels.

Health equity initiatives continue to be a high priority across DMS and partners. The Division of Quality and Population Health has created the Hub for Inclusion, Learning, and Action (HILA) which launched in July 2026. HILA incorporates several concepts from the Department's former equity team, the Racial Equity Core Team, while adding innovative approaches to improving department collaboration on health equity activities. The focus will be on inclusion of all people, learning about issues regarding health equity and how each division is approaching health equity in their everyday work by putting into action systems, policies, and procedures around health equity to reduce barriers and potential harm to Kentuckians.

The Population Health Branch has worked to revise the Government Alliance on Race and Equity (GARE) tool to align more closely with DMS work. Each DMS Division is requested to embed health equity into daily operations, projects, policies, contracts, and services. The purpose of the tool is to help identify how decisions affect equity either positively or negatively, mitigate any unintended negative consequences within the policy or program the tool is being used for, and develop ways to advance equity.

Please refer to Section 3.3 for a description of specific disparity initiatives associated with this Quality Strategy.

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Appendix A. Acronyms		
1.	AAP	Adults' Access to Preventive / Ambulatory Health Services
2.	AAF-E	Follow-up After Acute and Urgent Care Visits for Asthma
3.	ABHKY	Aetna Better Health of Kentucky
4.	ACA	Affordable Care Act
5.	ACS	American Cancer Society
6.	AD	Administrative Data (AD)
7.	ADV	Annual Dental Visit
8.	AHRQ	Agency for Healthcare Research and Quality
9.	AMM	Antidepressant Medication Management
10.	AMR	Asthma Medication Ratio
11.	AOD	Abuse and Dependence Treatment
12.	APM or APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics
13.	APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
14.	BAC	Beneficiary Advisory Council
15.	BCS or BCS-E	Breast Cancer Screening
16.	DBHDID	Developmental and Intellectual Disabilities
17.	BMI	Body Mass Index
18.	BPD	Blood Pressure Control for Patients with Diabetes
19.	CAD	Coronary Artery Disease
20.	CAHPS	Consumer Assessment of Healthcare Providers & Systems
21.	CBP	Blood Pressure Control Measures
22.	CC	Care Coordinator
23.	CCBHC	Certified Community Behavioral Health Clinics
24.	CCS or CCS-E	Cervical Cancer Screening
25.	CCSR	Clinical Classifications Software Refined
26.	CDC	The Centers for Disease Control and Prevention
27.	CLIA	Clinical Laboratory Improvement Amendments
28.	CMC	Clinically Meaningful Categories
29.	CNA	Comprehensive Needs Assessment
30.	CDC	Center for Disease Control and Prevention
31.	CGM	Continuous Glucose Monitoring
32.	CHFS	Cabinet for Health & Family Services
33.	CHIP	Children's Health Insurance Program
34.	CHOW	Community Health Outreach Worker
35.	CHW	Community Health Worker
36.	CIS or CIS-E	Childhood Immunization Status
37.	CKD	Chronic Kidney Disease
38.	CM	Care Manager
39.	CMS	Centers for Medicare & Medicaid Services
40.	CNA	Comprehensive Needs Assessment
41.	COL or COL-E	Colorectal Cancer Screening
42.	COPD	Chronic Obstructive Pulmonary Disease
43.	COVID-19	Coronavirus Disease 2019
44.	CPT	Current Procedural Terminology

45.	CRC	Colorectal Cancer
46.	CSHCN	Children with Special Health Care Needs
47.	DAIL	Department for Aging and Independent Living
48.	DBHDID	Department for Behavioral Health, Developmental and Intellectual Disabilities
49.	DBM-E	Documented Assessment After Mammogram
50.	DCBS	Department for Community Based Services
51.	DEA	United States Drug Enforcement Administration
52.	DJJ	Department of Juvenile Justice
53.	DHPSA	Dental Health Professional Shortage Areas
54.	DM	Diabetes Mellitus
55.	DMS	Department for Medicaid Services
56.	DPH	Departments of Public Health
57.	DQPH	Division of Quality and Population Health
58.	DRG	Design and development of the Diagnosis Related Group
59.	DSM	Diagnostic and Statistical Manual of Mental Disorders
60.	ECDS	Electronic Clinical Data System
61.	ED	Emergency Department
62.	EDU	Emergency Department Utilization
63.	EED	Eye Exam for Patients with Diabetes
64.	EMS	Emergency Medical Services
65.	EPSDT	Early and Periodic Screening, Diagnostic and Treatment Services
66.	EQR	External Quality Review
67.	EQRO	External Quality Review Organization
68.	FFS	Fee-for-service
69.	FIT	Fecal Immunochemical Test
70.	FMA-E	Follow-up After Abnormal Mammogram Assessment
71.	FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
72.	FPL	Federal Poverty Level
73.	FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence
74.	FUM	Follow-Up After Emergency Department Visit for Mental Illness
75.	FY	Fiscal Year
76.	GARE	Government Alliance on Race and Equity
77.	gFOBT	Guaiac Fecal Occult Blood Test
78.	CGM	Continuous Glucose Monitoring
79.	GSD	Glycemic Status Assessment for Patients With Diabetes
80.	HANDS	Health Access Nurturing Development Services
81.	HBD	Hemoglobin A1c Control for Patients with Diabetes
82.	HCV	Hepatitis C Virus
83.	HDO	Health Delivery Organization
84.	HEALTH	Helping to Engage and Achieve Long Term Health
85.	HEDIS	Healthcare Effectiveness Data and Information Set
86.	HIPAA	Health Insurance Portability and Accountability Act of 1996
87.	HIV	Human Immunodeficiency Virus
88.	HRA	Health Risk Assessment

89.	HRSN	Health-Related Social Needs
90.	HTN	Hypertension
91.	Humana	Humana Healthy Horizons in Kentucky
92.	ICD10	International Classification of Diseases, Tenth Revision
93.	IEES	Integrated Eligibility and Enrollment System
94.	IHI	Institute for Healthcare Improvement
95.	IMA or IMA-E	Immunizations for Adolescents
96.	IMD	Institutions for Mental Diseases
97.	IMR	Infant Mortality Rate
98.	IPRO	Island Peer Review Organization
99.	ISHCN	Individuals with Special Health Care Needs
100.	KCHIP	The Kentucky Children's Health Insurance Program
101.	KED	Kidney Health Evaluation for Patients with Diabetes
102.	KORE	Kentucky Opioid Response Effort
103.	KYNECT	Kentucky Health Benefit Exchange
104.	LOC	Level of Care
105.	LOINC	Logical Observation Identifiers Names and Codes
106.	LRCD	Low-Risk Cesarean Delivery
107.	LRCD-AD	Low-Risk Cesarean Delivery: Age 20 and Older
108.	LRCD-CH	Low-Risk Cesarean Delivery: Under Age 20
109.	LTSS	Long Term Services & Supports
110.	MAC	Medicaid Oversight and Advisory Committee
111.	MC	Managed Care
112.	MCO	Managed Care Organization, Managed Care Plan, Medicaid Managed Care
113.	MI	Myocardial Infarction
114.	MIC	Medicaid Innovation Collaborative
115.	MIS	Management Information System
116.	MSC	Medical Assistance with Smoking and Tobacco Use Cessation
117.	MY	Measurement Year
118.	NAS	Neonatal Abstinence Syndrome
119.	NCCI	National Correct Coding Initiative
120.	NCQA	National Committee for Quality Assurance
121.	NF	Nursing Facility
122.	NPA	National Partnership for Action to End Health Disparities
123.	ODA	Office of Data Analytics
124.	OED	Oral Evaluation, Dental Services
125.	OHE	The Office of Health Equity
126.	OIG	Office of Inspector General
127.	OMH	The Office of Minority Health
128.	OUD	Opioid Use Disorder
129.	PA	Prior Authorization
130.	PAHP	Prepaid ambulatory health plan
131.	Passport	Passport Health Plan by Molina
132.	PCCM	Primary Care Case Management
133.	PCE	Pharmacotherapy Management of COPD Exacerbation
134.	PCMH	Patient-Centered Medical Home

135.	PCMM	Primary Case Management Model
136.	PCP	Primary Care Provider
137.	PCR	Plan All-Cause Readmissions
138.	PDS-E	Postpartum Depression Screening
139.	PHE	Public Health Emergency
140.	PIHP	Prepaid Inpatient Health Plan
141.	PIP	Health Plan Performance Improvement Project
142.	PMs	Performance Measures
143.	PND-E	Prenatal Depression Screening
144.	POD	Pharmacotherapy for Opioid Use Disorder Total
145.	PPC	Prenatal and Postpartum Care
146.	PPEC	Pediatric Prescribed Extended Care
147.	PTDS	Post-Traumatic Stress Disorder
148.	PQI	Prevention Quality Indicator
149.	QAPI	Quality Assessment and Performance Activities
150.	QC	Quality Compass
151.	QI	Quality Improvement
152.	QIP	Quality Improvement Project
153.	QMAC	Quality Member Advisory Committee
154.	REL	Race, Ethnicity, Language
155.	SAA	Adherence to Antipsychotic Medication for Persons with Schizophrenia
156.	SDoH	Social Determinants of Health
157.	SDX	State Data Exchange
158.	SED	Serious Emotional Disturbance
159.	SFM-CH	Sealant Receipt on Permanent First Molars
160.	SFY	State Fiscal Year
161.	SGA	Substantial Gainful Activity
162.	SHIP	State Health Improvement Plan
163.	SKY	Supporting Kentucky Youth
164.	SMC	Cardiovascular Monitoring for Persons with Cardiovascular Disease and Schizophrenia
165.	SMD	Diabetes Monitoring for Persons with Diabetes and Schizophrenia
166.	SMI	Serious Mental Illness
167.	SMM	Severe Maternal Morbidity
168.	SNAP	Supplemental Nutrition Assistance Program
169.	SNS-E	Social Need Screening and Intervention
170.	SOGI	Sexual, Orientation, and Gender-Identity
171.	SPR	Spirometry Testing in Assessment and Diagnosis of COPD
172.	SSD	Diabetes Screening for Persons with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
173.	SSI	Supplemental Security Income
174.	SUD	Substance Use Disorder
175.	SURS	The Surveillance Utilization Review Subsystem
176.	TAC	Technical Advisory Committee
177.	TFC	Topical Floride for Children
178.	TSC-E	Tobacco Use Screening and Cessation Intervention

179.	T1DM	Type 1 Diabetes Mellitus
180.	T2DM	Type 2 Diabetes Mellitus
181.	UHC	UnitedHealthcare Community Plan
182.	UM	Utilization Management
183.	USPSTF	United States Preventive Services Task Force
184.	VBC	Value Based Care
185.	VBP	Value Based Payments
186.	WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
187.	WCV	Child and Adolescent Well Care Visits 3–21 Years of Age
188.	WIC	Women, Infants, and Children
189.	WellCare	WellCare of Kentucky
190.	W15	Well-Child Visits in the First 15 Months of Life
191.	W30	Well-Child Visits in the First 30 Months of Life

Appendix B: Roster of Interdisciplinary Team Members	
Name	**Organization**
Angela W. Parker	Division of Quality & Population Health, DMS, CHFS
LeeAna Trainer	Division of Quality & Population Health, DMS, CHFS
Troy Sutherland	Division of Quality & Population Health, DMS, CHFS
Lethia Harris	Division of Quality & Population Health, DMS, CHFS
Catherann Terry, RN, BSN	Division of Quality & Population Health, DMS, CHFS
Crystal Myatt, RN, BSN	Division of Quality & Population Health, DMS, CHFS
Rhonda Whitaker, RN, BSN	Division of Quality & Population Health, DMS, CHFS
Stephanie Patchen RN, BSN	Division of Quality & Population Health, DMS, CHFS
Gail Omidy, RN, BSN	Division of Quality & Population Health, DMS, CHFS
Kavya Kodadi	Division of Quality & Population Health, DMS, CHFS
Samantha Allen	Division of Quality & Population Health, DMS, CHFS
Lynn Mills	Division of Quality & Population Health, DMS, CHFS
Tina Gaines	Division of Quality & Population Health, DMS, CHFS
Leslie Yagel, RN, BSN	Division of Quality & Population Health, DMS, CHFS
Jamie Hurt-Mueller	Division of Quality & Population Health, DMS, CHFS
Leigh Ann Fitzpatrick	Division of Quality & Population Health, DMS, CHFS
Angela Sparrow	Division of Quality & Population Health, DMS, CHFS
Sherri Staley, BH Specialist	Division of Quality & Population Health, DMS, CHFS
Jeremy Armstrong-DeRossitt	Division of Health Plan Oversight, DMS, CHFS
Carmen Hancock	Division of Longterm Services and Supports, CHFS, DMS
Chantee D. Jordan	Division of Health Care Policy, CHFS, DMS
Kristi Beisell	BAC Coordinator
John Hoffmann	Division of Information Systems, DMS, CHFS
Loreenne P. Albillo	Commissioner's Office, Program Portfolio Management, DMS, CHFS
Carolyn Gallagher, PhD	IPRO, Director, Managed Care
Chuck Merlino	IPRO, Sr. Director, Managed Care
Leslie Hoffmann, PhD	Deputy Commissioner, DMS, CHFS
Olivia McBride	Medicaid Program Manager, Division of Information Systems, DMS, CHFS

Appendix C: Key Informant Interviews Analysis

Kentucky Medicaid Quality Strategy Analysis of Key Informant Interviews

Northern Kentucky University Institute for Health Innovation

July 7, 2022

(Continued on next page)

EXECUTIVE SUMMARY

In accordance with Federal Regulations states are required to establish and update a quality strategy to assess and improve the quality of healthcare services provided by managed care plans. CMS has provided guidance on the steps and suggested outcomes for this process. Kentucky is following this guidance in updating its current quality strategy which became effective in 2019. As part of this process, 20 key informants were identified and interviewed using a semi-structured instrument focused on key elements and strategic questions involving Medicaid in Kentucky. This document provides a summary of these interviews.

Key informants showed limited knowledge of the existing Quality Strategy but when reviewing the priority areas for this strategy concurred on their importance. Relative to the updated strategy, respondents agreed with the Interdisciplinary Team in prioritizing goals involving behavioral health, substance abuse, chronic diseases, and preventive care. Cross-cutting issues involved social determinants and health equity. A consistent observation was the need to coordinate the many initiatives and programs targeting disparities that are in process across stakeholder organizations. Beneficiary engagement was identified as a priority area for both DMS and the MCOs.

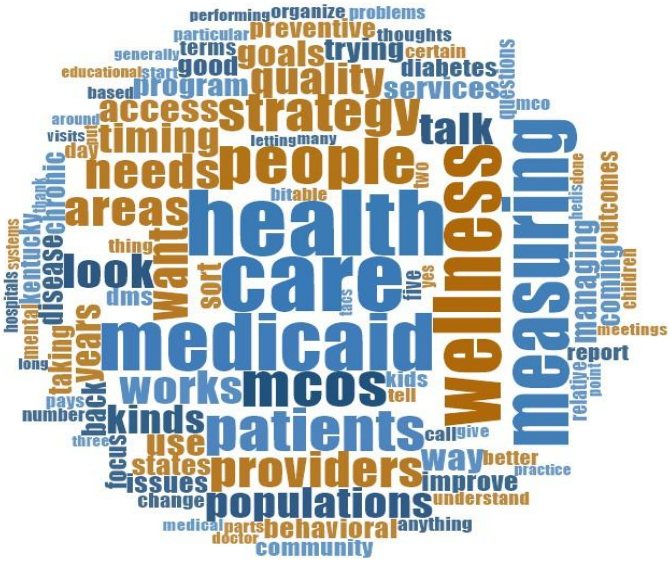
The two areas of greatest discussion were access to care and system costs/reimbursement levels. Access issues concerned availability of providers accepting Medicaid and appointments particularly for behavioral health care. Access to dentistry and optometry services were identified as being an acute issue. Network adequacy and geographic coverage in rural areas were also discussed by several key informants.

Reimbursement levels were discussed relative to system costs. The administrative burden of prior authorizations was a major issue highlighted as well as the complexity of dealing with multiple MCOs. The level of reimbursement and limitations on individual encounter complexity billing levels were identified as important barriers to access by discouraging provider participation.

There was overall agreement that payment and delivery reform are needed to drive Medicaid modernization in Kentucky. Value-based contracting and other outcome-based approaches were positively discussed. Concerning the measurement of the success of the Quality Strategy, there was a general discussion of the limitations of HEDIS measures, but agreement that there are few alternatives at this point.

This report contains a Hierarchy Map of the concepts and related domains discussed by the key informants as well as detailed summaries of the interviews.

Figure 1: Word Cloud for All Domains and Interviews



PURPOSE

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Toolkit (Toolkit) is prescriptive in recommending how states develop their strategy to assess and improve the quality of healthcare services provided by managed care organizations (MCOs). This includes recommending the nine-step process depicted in Figure 1. Kentucky is following these steps in developing its quality strategy.

Figure 2: CMS Recommended Process to Develop a Quality Strategy

The *Toolkit* also identifies cross-cutting considerations for the state to consider when developing the strategy. To augment and inform the activities of the interdisciplinary team (step 1) and to address cross-cutting issues, formal interviews of key informants were added to the information-gathering process (step 3). This document provides a summary of the interview process and outcomes.

METHODOLOGY

A semi-structured interview instrument was developed by NKU and reviewed by the Kentucky Department of Medicaid Services (DMS) quality team. This instrument is available in the appendix. The instrument was organized based upon the following:

- Knowledge and experience with the current Medicaid Quality Strategy
- Considerations of the areas and domains established by the Interdisciplinary Team as priorities for goals and objectives
- Potential measures to assess the quality of Medicaid services
- Discussion and insights concerning disparities, health equity, and social determinants
- Barriers and facilitators of access to care
- Payment reform initiatives including value-based care

A purposive sample combined with the snowball technique (i.e., using study participants recommendations for other individuals to include) was used to identify key informants. Informants were primarily drawn from the Kentucky Medicaid Technical Advisory Committee (TAC). In total, 22 individuals were identified as key informants, and 20 agreed to be interviewed. Interviews lasted for approximately 60 minutes and were conducted over Zoom. Interviews were recorded, transcribed, and coded using NVivo qualitative analysis software to facilitate thematic analysis. A list of interviewees, their affiliation, and date of interview is provided in Table 1.

Payer organizations were not included in the key informant interviews because all six managed care organizations already had multiple representatives on the Interdisciplinary Team and the focus-area sub-teams. Thus, the Interdisciplinary Team is the principal means of input from the MCOs at this initial stage of

the strategy development, and the key informant interviews were used to access input from other significant healthcare stakeholders across the Commonwealth. All stakeholders will have additional opportunities for comment in response to the initial draft of the strategy and during the public comment period.

Table 1: Key Informants Interviewed

Quality Strategy Interviews		
Name	**Affiliation**	**Date of interview**
Jerry Roberts, DPM	Podiatrist MAC Member Represents KY Board of Podiatry	March 2, 2022
Sheila Schuster, PH.D.	Psychologist Behavioral Health TAC Chair	March 2, 2022
Peggy Roark	Advocate MAC Member Medical Assistant Recipient	March 2, 2022
Steve Compton, OD	Optometrist MAC Member Represents KY Optometric Association Optometric TAC Member	March 7, 2022
Garth Bobrowski, DMD	General Practitioner/Dentist MAC Member Represents KY Dental Association Dental TAC Chair	March 7, 2022
Ashima Gupta, MD	Pediatric Ophthalmologist MAC Member Represents KY Medical Association Physicians TAC Member	March 8 2022
Terry Skaggs	Chief Financial Officer, Wells Health Systems, Owensboro, KY Nursing Home Care TAC Chair	March 10 2022
Steve Shannon	Executive Director, KARP Association Persons Returning to Society from Incarceration Behavioral Health TAC Chair	March 10 2022
Matthew Burchett, O.D.	KY Optometric Association, Optometric TAC Chair	March 10 2022
Charles Thornbury, MD	Medical Director, Multi-Specialty Clinic Glasgow, KY Physicians TAC Chair	March 10 2022
Annlyn Purdon, MBA, MACC	Home Health Home Health TAC Chair	March 15 2022
Beth Ennis, PT, EdD	Pediatric Physical Therapist Therapy TAC Chair KY Physical Therapy Association	March 16 2022
Ron Poole, R.Ph	Pharmacist Pharmacy TAC Chair	March 17 2022
Beth Partin, APRN	Nurse Practitioner MAC Member Represents KY Nurses Association	March 21 2022
Mahak Kalra, MPH	Kentucky youth advocate Children's Health TAC Chair	March 25 2022
Beverly Williams-Coleman, DNP, APRN	Advocate Nursing Services TAC Chair	March 25 2022
Emily Beauregard, MPH	Director, Kentucky Voices for Health Consumer Rights and Client Need TAC Chair	March 25 2022
Russ Ranallo, M.S.	Hospital Finance Hospital Care TAC Chair	March 30 2022
Melanie Landrum, CPC & team	Kentucky Hospital Association	March 30 2022
Pat Purcell, MD	Office for Children with Special Health Care Needs (OCHSN)	April 22 2022

FINDINGS

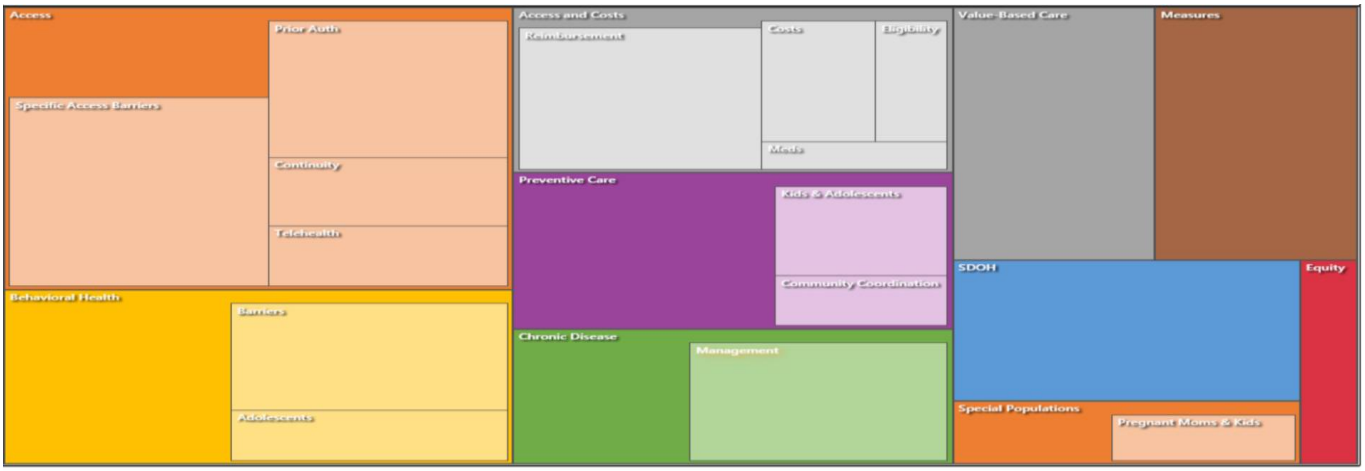
This section first describes an overall review and summary of the responses by the key informants. The second section provides a more thorough assessment for each of the identified principal domains and factors, and the final section summarizes the discussion of cross-cutting and priority issues.

Hierarchy Map

There was considerable consistency by the key informants in the identification of challenges needed to be addressed in the Kentucky Medicaid Quality Strategy. Figure 1 provides a hierarchy map for the relative count for the factors identified and their key sub-elements. These factors are based on the draft goals and objectives identified by the Interdisciplinary Team. In addition, interviewees suggested new factors beyond those from the draft goals and objectives and these are included in the Map as well.

Figure 3: Hierarchy Map for Key Informant Responses

This tree map represents the relative coding of content for each concept node. The rectangles should be considered in relation to each other and are scaled for the best fit. The greater the overlap of shared comments, the more proximal the positioning between the concepts (e.g., closer). The amount of content coded may reflect complexity rather than importance. For example, more complex issues such as access to care may have had a more detailed discussion than preventive care and therefore have more coded elements and be represented by a larger rectangle.



Summary of Responses

Key informants showed limited knowledge of the existing Quality Strategy. Only two respondents indicated that they were very familiar with the strategy. While generally aware of the existence of the External Quality Reviews (EQR), few respondents indicated a familiarity with their findings.[17] Relative to meeting the targets for the existing Quality Strategy, respondents reflected a general need for substantial improvement across all priority areas.

However, one priority area in which respondents indicated they perceived improvement was the prioritization of substance abuse disorder. While acknowledging continuing severe problems with access to care, the general view was that stakeholders have prioritized activities designed to address Kentucky's substance abuse crisis; one respondent described it as a "great push."

The two areas of greatest discussion were access to care and system costs/reimbursement rates. Both were cross-cutting issues. Access issues primarily concerned network adequacy, including appointment availability, lack of service in rural areas, behavioral health and substance abuse care availability, and the number of providers accepting Medicaid patients. Access to dentistry and optometry services were identified as particular problems that are sometimes overlooked. Given the experiences with the expansion of telehealth during the pandemic, key informants were consistently positive about the potential for its use to ameliorate some degree of the issues with access in the future.

Reimbursement was discussed within the context of system costs. Low reimbursement rates were identified as potentially creating Medicaid as a loss leader for health systems and individual providers. This affects access by potentially limiting the number of available appointments due to the need to optimize the reimbursement-type mix. The second area of reimbursement concerned the administrative time and effort required in the prior authorization (e.g., pre-certification) process, including varying policies across DMS and MCOs, and the complexity of dealing with up to six MCOs.

In identifying priority areas for targeting, key informants agreed with the Interdisciplinary Team regarding prioritizing goals that involve behavioral health, substance abuse, chronic diseases, and preventive care. No additional priority areas were recommended. Challenges and barriers to achieving objectives related to goals in these areas were identified, particularly as they relate to the complexity of caring for underserved and special populations.

Health disparities, health equity, and social determinants were discussed as issues crosscutting all potential strategy goals and objectives. Beneficiary engagement was identified as the key barrier in dealing with both the Department for Medicaid Services and the MCOs. This challenge included web site navigation and beneficiaries' understanding of the system and processes. Key informants universally welcomed the increased emphasis on disparities and equity in the Quality Strategy.

Among the key informants, providers reflected a general appreciation of the need for delivery and payment reform efforts. Value-based contracting (VBC) was the approach most discussed, with respondents indicating confusion about the various approaches to VBC across the six MCO organizations and concern about contracts that include the possibility of penalties, as opposed to contracts that are based only on the sharing of cost-savings.

Interviewees were asked to discuss potential measures that can be used to track the goals and objectives of the Quality Strategy. The importance of evidence based and standardized HEDIS measures were acknowledged. Providers have experience with these measures in other programs and exhibited a level of comfort with them. There was a general discussion of the limitations of administrative data.

Clinical data were deemed burdensome to capture and unreliable across electronic health record systems.

Domain Review

This section provides an analysis of the responses by the key informants categorized by topic. Given the interrelationships between the challenges faced by Medicaid, there was substantial overlap in the priorities and issues identified. These are highlighted in the descriptions below and discussed in greater detail in the Cross-Cutting Issues section.

<u>Access</u>

Issues of access were part of the key informant discussions across all domains. For this analysis, we organize access into two domains. The first concerns more general issues of access and the second is access and cost or the financial/economic factors affecting access. The components are

summarized in the figure below.

The most cited specific access issue was availability of providers and appointments for Medicaid beneficiaries. For example, one stakeholder observed the need to "make it more accessible. Make it more convenient. Make it easier. Incentivize providers to go into communities that are unstaffed, that don't have sufficient .... doctor(s), APRNs, I don't care who it is." A shortage of dentists and optometrists willing to serve Medicaid patients in all geographic settings was also identified.

Transportation was acknowledged as an ongoing specific problem. Most informants indicated that non-emergency medical transportation (NEMT) has improved and is generally available. Others indicated that NEMT is complex with inconsistent policies and coverage including the challenges with beneficiaries knowing about and using these services within their region continues. The problem with transportation overlaps with social determinant impacts.

Additional specific barriers to access discussed included the ability for providers to make appropriate referrals for pediatric patients without concerns for delays, the ability to prescribe the most appropriate medication without having to complete an excessive amount of paperwork, the ability of school personnel to communicate with other service providers to students in order to improve continuity of care.

Nearly one-quarter of all comments about access to care involved the prior authorization process. Key informants cited the burden and costs from the time and effort required to receive pre-certification. One provider stated, "if you don't get the pre-cert, you don't do the visit. We often still do the visit and know it's just for free." Another provider stated, "it feels like they (MCOs) are constantly denying visits, and I know there is probably some good reason for that ..., yet patients don't seem to get the services that they need approved."

Dealing with six different MCO organizations for prior authorization and billing was also a commonly cited issue. A stakeholder provided this overview:

There are some MCOs who don't require prior authorization for the first 20 visits because that's what's allowed within the plan. Others require authorization after the evaluation. The ones that do require authorization may have different requirements for what you turn in as far as paperwork or how you submit that. Is it all electronic? Do you have to fix it? What's required to do what's called a 'peer to peer' where you talk to another professional of the same discipline to talk through what you want, why you want it? What triggers that? So, it's just remembering seven (SIC) different processes and then monitoring each of those processes as they continually change moving through the year. So, if there could be some consistency, that would be wonderful.

The net effects of prior authorization were identified as increasing system costs, requiring additional administrators, distracting providers from caregiving, and creating disincentives for seeing Medicaid patients.

Continuity of care was also identified as a key barrier in access to care. The continuity of care concern was primarily around availability to specialists. For example, one provider stated, "When I make referrals, sometimes if it's not an emergency, it's three months before someone can be seen, and that is really not acceptable for any condition." For behavioral health, stakeholders indicated there were often few or no providers to refer patients to.

Approximately 10% of the comments concerning general access to care concerned the potential for telehealth. Key informants pointed to what they perceived to be positive results associated with the expansion of telehealth in response to the Covid-19 pandemic.

<u>Cost</u>

The cost of providing Medicaid services and the level of reimbursement were areas of substantial

discussion by the key informants. Similar to the prior authorization issue described above, providers indicated that the administrative burden combined with the level of Medicaid reimbursement and the challenges of engaging the Medicaid population create barriers to access. As one provider described the problem, "with the Medicaid reimbursement being what it is, being significantly lower than anything else out there, providers can't spend non-billable time dealing with all of the administrative burden to try and get somebody back in the door who may or may not show up for little money."

System costs were discussed as a problem relative to the time and effort required to pre-authorize a patient visit and receive approval and reimbursement for activities during the encounter, which includes the complexity of dealing with multiple MCOs. Reimbursement levels were seen as often not meeting costs. Patients' cases are often complex, and providers are sometimes limited to billing at higher levels for only two annual visits. Some respondents also indicated a need for equivalent reimbursement for services regardless of provider credentials or type.

The principal issue identified was the level of reimbursement. As one interviewee indicated, "A lot of the folks [providers] that are taking Medicaid, they're the only ones in the area taking Medicaid, and so they get them all. And if half your patients don't show up and that's all you can get on your list, you can't keep your lights on with what they're being reimbursed."

Similarly, beneficiaries described challenges with understanding eligibility, finding in-network providers, scheduling appointments, and transportation. Providers and beneficiaries both indicated some challenges dealing with DMS as well as with MCO websites.

A final cost-related concern was changes to formularies. Providers, particularly those in behavioral health, were concerned when patients were shifted from an effective medication to new medicines based upon changes to formulary. One provider had the following observation:

What the MCOs are doing is shaping the prescribing of those professionals that have prescriptive authority. Because what happens is it's so hard to really prescribe the particular drug that I think is going to be best for you as my patient because I know that I'm going to have to do X number of faxes and X number of appeals and so forth. And so, you shape my behavior because I have so many more patients to see and so forth. And so, I just take the path of least resistance and put somebody on a different medication that is not actually what I think they ought to be on.

In summary, barriers associated with access and cost included (1) administrative burdens connected to prior authorization (pre-certifications) for Medicaid beneficiaries, (2) low reimbursement levels, (3) the need for equivalent reimbursements regardless of type of practice, (4) inadequate networks, and (5) changing formularies.

Behavioral Health

Behavioral health was identified as a top priority for the quality strategy by all key informants. The primary points of discussion were the related issues of access and network adequacy. As described by one interviewee, "Mental health issues are coming more to the forefront. And so, we need to continue our efforts and wrap around as much [*sic*] services and support to families, and kids, in particular."

The most commonly cited problem was access to providers for both inpatient and outpatient services. Ability to access to inpatient services was described as particularly acute, but access to care cut across all settings, with the problem being greatest in rural settings. In an interview one beneficiary summed up the problem: "I've been trying to call and find me a counselor myself, and I haven't had any luck." Stigma was also cited as a barrier, with the stigma associated with walking into a local community mental health center preventing some adults from seeking behavioral health services.

The legal requirements also create a barrier to receiving MOUD. Kentucky requires APRNs to have a collaborative prescribing agreement with a physician to prescribe scheduled drugs. These agreements can be difficult to establish. As one APRN described the problem, "... [In] order to prescribe MAT, you have to have a collaborative prescribing agreement with the physician who also does MAT. And so, if you can find a physician who does it, then you have to find a physician who's willing to sign an agreement. And that's been difficult."

The general opinion was that children and adolescents have better access to behavioral health care than adults. Parents tend to be more willing to get mental health services for their children than for themselves, and there are resources available for youth within school systems.

Most of the issues identified are not under the direct influence by the MCOs. Two issues described as concerns were formulary changes and its' the impact on medication adherence and prior authorization. These were discussed above.

Chronic Disease Management

Chronic diseases as a population health problem were discussed across all informants. The poor performance relative to national benchmarks, as reported in *t* the *2021 External Quality Review Technical Report Review of MCO Contract Years 2018 to 2020*, was pointed out in several interviews. Chronic diseases and their management continue to be a priority in establishing goals and objectives for the strategy. Typifying the responses was the statement from one provider interviewed:

Social determinants of health, mental health, those kinds of things are truly critical, especially for the population that we're talking about. Diabetes management, all of those kinds of things are really important. Obviously, smoking has been an issue. Opioid management is an issue for this state that's really problematic. So, I think that the targets [in the previous Quality Strategy] were appropriate. I think we can probably do some more.

The main issues identified with chronic diseases and chronic disease management are (1) the need for better patient education, (2) better coverage to allow for proper chronic disease management, and (3) the effects of lifestyle choices on chronic diseases. The connection between mental health and chronic diseases was also discussed as a priority.

Relative to MCO performance and targets, respondents discussed issues of access, formulary, prior authorization, and general network adequacy. All these topics are discussed in previous sections. Regarding beneficiary engagement education, key informants identified a perceived need to better coordinate the engagement and education activities across MCOs and with initiatives by DMS.

In summary, the key informant interviews confirmed that the focus on chronic disease measures identified by the interdisciplinary team are priorities.

Preventative Care

The discussions concerning preventive care paralleled those for the earlier domains. However, there was relatively more discussion with greater overlap with the Social Determinant and Equity domains (data).

Comments centered on access to care, beneficiary engagement for preventive services, and the

challenges getting individuals to use preventative care. For example, one informant stated, "Some people don't know how to use it [healthcare]. And, if you've never had it, how would you know how to use it, you know, to go for an annual physical exam?"

Of interest, several discussions including the importance of coordination with community health workers and community organizations to bridge inequity and social determinants. This was also discussed as an area where there could be better coordination with the MCOs, such as: (1)

engagement between MCO outreach activities and organizations active in the community and (2) a better understanding of the activities of the community health workers employed by the MCOs.

Preventive care for adolescents was also discussed. There, the focus was on nutrition and physical activity counseling as initiating a healthy lifestyle at an early age. Other observations centered on childhood immunizations as a priority, particularly given their fall-off during the Covid-19 pandemic.

Overall, there was consensus in the comments. The key informants universally agreed preventive care should be a priority goal in the Quality Strategy.

Social Determinants of Health

As described in the earlier sections, SDoH is a cross-cutting issue across all the Domains. Key informants universally recognized the importance of the issue in the Quality Strategy. Suggestions focused primarily upon engagement to attract the beneficiaries into care. One interviewee observed that "the vast majority of folks can have a Medicaid benefit now who need it, 100 percent of poverty. And for some unknown reason, we haven't made a conscientious decision to ensure people [who] have access to health care are using it." A similar description of the problem was provided in another comment, who connected the problem to access: "How do we look at groups who may be less likely to access services to their detriment? And how do we engage with those communities? Again, it comes back to that access issue."

Once again, there was a discussion about how to coordinate the various activities in the area of social determinants across multiple organizations in the Commonwealth. As one key informant indicated, "We're all collecting information of food insecurity and housing insecurity and transportation barriers." The suggestion was this information, and the activities of various programs, need to be coordinated.

In summary, SDoH were identified as cross-cutting and of the highest priority in the state. When discussing social determinants of health, a common theme was the need to reduce the administrative burden associated with getting reimbursed for Medicaid patients; if this administrative burden were to be reduced, more providers may be willing to see these patients. Access was also a common theme. The importance of community programs was discussed, to have someone in the community develop relationships with people and help guide them on utilizing resources and accessing care. The need to address food and housing insecurities, as well as transportation barriers, was also discussed.

Health Equity

Like SDoH, health equity was a cross-cutting issue across all the domains. All key informants identified the area as central to developing the Quality Strategy. The range of comments were limited, with similar observations across all informants. Thus, the Hierarchy Map indicates a relatively small space for this topic, even though it clearly was one of primary importance.

Interviewees pointed to the increased focus on health equity by all stakeholders, including data collection by DMS, MCOs, and health systems. Kentucky is also creating a health equity TEP and an Equity Branch within CHFS. These activities were acknowledged as a starting point in what is a very challenging area.

Access was the area most discussed topic within health equity. A summary of the discussions is that equity should be addressed by ensuring beneficiaries know how to utilize their coverage and what services they should access and how often. An initial step would be to offer guidance to help them navigate the complex healthcare system. Health equity should be among the highest priorities of the state.

Special Populations

The discussions were directed toward what special populations should be prioritized and comments on the two areas proposed by the Interdisciplinary Team: pregnancy and newborns and foster children.

The key informants agreed on prioritizing pregnancy and newborns, but they reflected limited knowledge of the situation for foster children. One special population discussed for potential inclusion was justice-involved individuals and the overlap with behavioral health and SUD.

Specifically, the discussion of special populations brought up concerns about (1) the need to provide necessary postpartum care prior to discharge, (2) prioritizing childhood immunizations, and (3) ensuring medical coverage for the duration of pregnancy to ensure appropriate prenatal care is received. Two main issues that were identified regarding newborns and youth were low birth weights and adolescent obesity.

The discussion suggests there is likely a need for CHFS to do greater education about foster children as a special population to stakeholders. For justice-involved individuals, several interviewees pointed to the anticipated 1115 Waiver for reimbursement and continuity of care for incarcerated individuals with an SUD diagnosis as a starting point for this special population.

Value-Based Care

Key informants were largely aware of value-based payment approaches to reimbursement. For obvious reasons, beneficiaries and some advocates had limited knowledge of these schemes. There was general support for the concept of value-based care and the need for this payment method to improve population health. As summarized by one provider, “I think value-based purchasing is the future. I think we have to figure that out. I think the challenge is what’s the value? What’s the outcome?”

One consumer advocate suggested, “If we could focus our attention on wellness, prevention and that value-based purchasing, and we all feel comfortable with what the value is and how it’s being

purchased, we can move the Medicaid program.” As far as a direction forward, one provider suggested learning from best practices in other states stating, “I now see the growing trend of value-based care…it’s important to kind of engage in ongoing trends that are happening nationally and see what ways that we can plug in.”

One criticism of value-based care concerned the degree to which patient behavior is outside of the influence of the provider. One provider observed, “You don’t have any control over where the patients are going for their care… And so, you know, the providers are being judged by a patient being seen by other providers … So, it’s difficult for any provider to drill in there to see if the patient is getting the preventive care, the lab work that they need.” Other criticisms included the role of social determinants relative to interaction with the health system. For example, a provider stated, “It’s also not very helpful when you’re trying to look at the measures and if the providers are meeting the measures because the patients don’t have to come and see them [the providers], so you don’t have an opportunity to meet the measures.”

In sum, respondents with an understanding of value-based care agreed that it should be an integral part of Kentucky’s Medicaid Quality Strategy. However, there were few specific suggestions beyond a focus on prevention and management.

Measurement

Key informants had many opinions on outcome measurement. Controversy is not unique to Medicaid, and it also surrounds other national programs such as the MIPS (merit-based incentive

payment system) and APMS (alternative payment models). A primary criticism as described by one interviewee was "a lot of quality measures, … and the majority of HEDIS measures, are more squarely directed at primary care doctors." Another stated, "It's really hard to do those kinds of measurements on the behavioral health side, and I think that by default, in some ways, we end up focusing on them."

Other providers indicated that they viewed measures as primarily an administrative task with little impact on care. A provider commented, "We're providing the best care we can for our patients. And we did that before all these quality measures came out, and I don't think any of us have changed the way we practice since the quality measures came out." Another observed, "I don't think [the quality measures] changed the way we practice so much as it's forced us to take more time checking boxes on a health record."

The discussions provided no specifics on alternative measurements. There was a recognition that HEDIS measures are evidence-based, supported by CMS, used in other programs (e.g., Medicare), and allow for comparisons across providers and states. While clinical measures would likely provide greater insight into processes and outcomes, they were viewed as too complicated to capture and a potential additional burden. Thus, administrative data, such as claims, need to be the basis for measurement.

In sum, the previous Quality Strategy focused on many critical issues for Medicaid beneficiaries in Kentucky, but key informants suggested there is a need for a stronger link to measures that support value-based care. There is a general support for HEDIS measure use, but it was discussed that there is a need for population-specific measures. However, some providers believe that measures do not influence how they practice; instead, they just create more tasks to check off boxes in a patient's health record.

Cross-Cutting Issues

As apparent in the discussion of the individual domains, all the priority areas are interrelated and have cross-cutting implications. Chronic disease management, preventative care, behavioral health, and targeted care for special populations are clear priorities for Kentucky. Each of these are shaped by the cross-cutting issues of social determinants/ health equity, access to care, and system/payment reform. These issues are summarized below:

- Social Determinants/Health Equity – There are clear challenges of disparities in the population of Kentucky Medicaid beneficiaries and the access to care, especially as it relates to social factors and geography. This will be a priority in the Kentucky Medicaid Quality Strategy. Initial planned steps include capturing sub-population measures across all quality domains, SDoH measures being standardized and formally required, and an initiative to understand and coordinate all of the SDoH/disparities/health equity initiatives underway in Kentucky.
- Network Adequacy – This issue is complex and is more than descriptive statistics of providers and regional coverage. The Quality Strategy needs to wrestle with formidable barriers to access, including the number and type of providers and appointments available, administrative costs associated with prior authorization and billing, and relative reimbursement levels.
- System/Payment Reform – Related to cost as a barrier to access, all stakeholders agreed that Medicaid needs to move to a reimbursement model focused on quality of care and outcomes, such as value-based payments/contracting. This is a national trend and CMS requires the Quality Strategy to include this cross-cutting issue.

Appendix D: Glossary of Terms	
External quality review (EQR)	The analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health services that an MCO, PIHP, PAHP, or PCCM entity (described at 42 CFR 438.310(c)(2) and in CHIP at 42 CFR 457.1240(f)) or their contractors furnish to Medicaid and CHIP beneficiaries.
External quality review organization (EQRO)	An organization that meets the competence and independence requirements set forth at 42 CFR 438.354 (applicable also to CHIP managed care programs per 42 CFR 457.1250[a]) and performs EQR or other EQR-related activities as set forth in 42 CFR 438.358 (applicable also to CHIP managed care programs per 42 CFR 457.1250[a]), or both.
External quality review (EQR)-related activities	Mandatory and optional activities, such as PIP validation and performance measure validation, completed for annual EQR. EQR-related activities may be conducted by the state; its agent that is not an MCO, PIHP, PAHP, or PCCM entity (described at 42 CFR 438.310(c)(2) and in CHIP at 42 CFR 457.1240(f)); or an EQRO. See 42 CFR 438.358.
Managed Care Organization (MCO)	An entity that has a comprehensive risk contract under 42 CFR Part 438, and that is (1) A Federally qualified Health Maintenance Organization that meets the advance directives requirements of subpart I of Part 489; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; (ii) Meets the solvency standards of 42 CFR 438.116.
Managed care plan (MCO)	For the purposes of quality strategy requirements, includes MCOs, PIHPs, PAHPs, and PCCM entities described in 42 CFR 438.310(c)(2) and 42 CFR 457.1240(f).
Measure/Metric	For the purposes of this toolkit, used to monitor the performance of MCOs at a point in time, to track plan performance over time, to compare performance among plans, and to inform the selection and evaluation of quality improvement activities.
Performance improvement project (PIP)	An intervention that is designed to achieve and sustain significant improvement in health outcomes over time. In the Medicaid and CHIP managed care context, PIPs are defined by the state agency and implemented by the MCO.
Prepaid ambulatory health plan (PAHP)	An MCO under contract with the state that provides services to enrollees on the basis of capitation payments or other payment arrangements that do not use state plan payment rates; does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.
Prepaid inpatient health plan (PIHP)	An MCO under contract with the state that provides services to enrollees on the basis of capitation payments or other payment arrangements that do not use state plan payment rates; provides, arranges, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.
Primary care case management (PCCM) entity	An entity which provides functions such as case management and enrollee education in addition to PCCM services. For the purposes of this toolkit, the term PCCM entity only applies to those PCCM entities whose contracts with a state provide for shared savings, incentive payments, or other financial reward for the PCCM entity for improved quality outcomes, as described at 42 CFR 438.310(c)(2). For CHIP, the term

	applies to a PCCM entity whose contract with the state provides for shared savings, incentive payments, or other financial reward for improved quality outcomes, as described at 42 CFR 457.1240(f).
Quality	The degree to which an MCO, PIHP, PAHP, or PCCM entity (described at 42 CFR 438.310(c)(2) and 42 CFR 457.1240(f)) increases the likelihood of the desired health outcomes of its enrollees through structural and operational characteristics; the provision of services that are consistent with current, professional, evidence-based knowledge; and interventions for performance improvement.
Quality Strategy	A written strategy to assess and improve the quality of Medicaid and CHIP managed care services within a state per 42 CFR 438.340 and applicable also to CHIP managed care programs per 42 CFR 457.1240(e).